A T A G L A N C E
BROUGHT TO YOU BY THE ST. JOHNS COUNTY SELF-FUNDED PLAN

MANDATORY
2013 OPEN ENROLLMENT
October 1 - October 31
Open Enrollment is mandatory and must be completed between October 1 and October 31.

WHAT’S INSIDE:

rates.......................................................... 3
understanding your plan options.................. 4
qualifying events & benefit changes.............. 4
medical plans............................................. 5
prescription, dental and vision plans............. 6
how to find a doctor/know before you go...... 7
flexible spending accounts......................... 8
health reimbursement account..................... 9
employee assistance program....................... 10
accident (firefighters only)......................... 10
basic life & AD&D/optional life.................... 11
long-term and short-term disability.............. 12
online enrollment..................................... 13
legal notices............................................ 14-19
contacts................................................. 20

PRODUCED BY:
The St. Johns County Self Funded Medical Plan offers an extensive benefit package to all qualified employees. This booklet will assist you in understanding your various benefit options, including medical, dental, vision, prescription, long-term & short-term disability, basic and optional life insurance and flexible spending accounts (FSA) available to you effective January 1, 2014.

Our health plan is self-funded for its medical, prescription, dental and vision coverage. When your premiums are deducted from your paycheck, they are kept in a health fund, along with the monies that St. Johns County contributes toward your health insurance. This fund is then used to pay medical, prescription, dental and vision claims for all St. Johns County employees. The St. Johns County Self Funded Plan has been well-managed, allowing us to continue offering an array of benefit choices, but healthcare costs continue to rise. While our Health Plan has historically experienced increases below the national average, we need to continue planning for the future to ensure that our health fund remains financially stable. Because the St. Johns County Medical Plan is self funded, it is up to employees to take control and responsibly manage their health conditions in order to maintain and even decrease the cost of our Plan.

Our Plan cannot be sustained for the long-term without every employee working to lower their risk and improve their health, which will help to decrease claims costs and ultimately, prevent employee contributions from increasing. Cost-saving techniques include choosing urgent care centers over the emergency room, choosing generics instead of brand-name medications, comparing medical costs before going to the doctor, and participating in the County Wellness Program including the voluntary Personal Health Assessment (PHA).

For 2014, there are several changes including the addition of a new high deductible option and a $50 per month premium credit by completing the PHA. This booklet highlights many useful tools that can help you with your health care choices and help you become a better health care consumer. If you missed one of the many benefits overview sessions, for your reference a power point is available on the County’s intranet and at www.sjcbcc.benergy.com.

It continues to be our goal to provide a comprehensive healthcare program for you and your family that is dependable, affordable, and allows broad access to most physicians, hospitals, and pharmacies. Please use this booklet to research your benefit options in order to decide whether you would like to continue your current coverage through 2014. The month of October 2013 is Open Enrollment, providing you the opportunity to adjust your benefits as you see fit. During Open Enrollment you can add or delete yourself or any dependents from coverage effective January 1, 2014. After October 31, 2013, however, you will not be able to enroll or terminate your coverage until next year's Open Enrollment unless you experience an IRS approved qualifying event. Examples of an approved qualifying event include marriage, divorce, having a baby, or a spouse losing his/her employee coverage. You must enroll online within thirty (30) days of experiencing a qualifying event.

To help us ensure the most accurate information and to receive the benefit of the PHA credit, you must log on and complete online enrollment. When reviewing your benefits online, here are some things to consider:

☐ Would you like to change your benefits or delete/add any dependents?
☐ Are you currently enrolled in a Flexible Spending Account (FSA) or Dependent Day Care Account (DDC)?
  ☐ You must complete a new FSA election for 2014 if you choose to re-enroll in either Flexible Spending Account.
  ☐ Please note that the maximum contribution for the FSA is $2,500. The maximum contribution for the DDC is $5,000.
☐ Would you like to participate in an FSA?
☐ Would you like to enroll in the Optional Life Insurance or Voluntary Short-Term Disability programs?
☐ Are your beneficiaries up to date?

After reviewing the information contained in this booklet, should you have benefits questions, please call the Personnel Services Benefits Team at 209-0635, Option 5.

Wishing you a healthy and successful 2014!

Michael D. Wanchick
St. Johns County Administrator
Who is Eligible for Benefits?

**Eligible Employees:** Employees of St. Johns County scheduled to work at least 30 hours per week and have met the waiting period of 1st of the month following 60 days of employment.

**Eligible Dependents**:  
1. Your Legal Spouse as defined by the State of Florida.  
2. Your natural, newborn, Adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) will be covered to the end of the month in which he or she reaches age 26.  
3. The newborn child of a Covered Dependent’s child will automatically terminate 18 months after the birth of the newborn child.  
4. In the case of a handicapped dependent child, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 26, if the child meets the requirements as set forth in the Florida Blue Benefit Booklet, which is available at www.sjcbcc.benergy.com.

### 2014 Monthly Rates:

*All full-time employees who are covered under the Medical plan are automatically enrolled in the Vision, Dental and Prescription Plans.*

#### OPTION A: MEDICAL BLUE CHOICE PPO

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Standard Rate</th>
<th>Credit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$193.00</td>
<td>$143.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$400.00</td>
<td>$350.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$312.00</td>
<td>$262.00</td>
</tr>
<tr>
<td>Family</td>
<td>$519.00</td>
<td>$469.00</td>
</tr>
</tbody>
</table>

#### OPTION B: MEDICAL BLUE OPTIONS PPO*

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Standard Rate</th>
<th>Credit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$ 50.00</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$225.00</td>
<td>$175.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$175.00</td>
<td>$125.00</td>
</tr>
<tr>
<td>Family</td>
<td>$330.00</td>
<td>$280.00</td>
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</table>

#### OPTION C: MEDICAL BLUE OPTIONS HDHP/HRA*

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Standard Rate</th>
<th>Credit Rate</th>
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</thead>
<tbody>
<tr>
<td>Single</td>
<td>$ 50.00</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$200.00</td>
<td>$150.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$150.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>Family</td>
<td>$280.00</td>
<td>$230.00</td>
</tr>
</tbody>
</table>
Plan Changes for 2014

- Blue Choice
  - **Calendar Year Deductible (CYD)** increasing to $500 (Individual) and $1,500 (Family)
  - **Out-of-Pocket Maximum** increasing to $3,000 (Individual) and $7,500 (Family). Out-of-Pocket Maximum will include the deductible, medical copays, coinsurance and prescription copays.

- Blue Options
  - **Out-of-Pocket Maximum** increasing to $3,000 (Individual) and $9,000 (Family). Out-of-Pocket Maximum will include the deductible, medical copays, coinsurance and prescription copays.

- **Medical Plan Option C added**—Blue Options High Deductible Health Plan (HDHP) and Health Reimbursement Account (HRA). St. Johns County will contribute $600 per year into your HRA.

- **Prescription Copays** increasing to $50 for Preferred Brand and $75 for Non-Preferred Brand.

- **Voluntary Life and Short-Term Disability**—Guaranteed issue, no medical questions asked, during 2013 Open Enrollment only!

What is a High Deductible Health Plan (HDHP) and Health Reimbursement Account (HRA)?

A third plan option – **Option C**—has been added for January 1, 2014. This is a health reimbursement account (HRA) combined with a Blue Options high deductible health plan. A **high-deductible health plan (HDHP)** is a health insurance plan with lower premiums and higher deductibles than a traditional health plan.

- If you elect the HDHP, St. Johns County will be contributing $600 per year into your HRA, beginning 1/1/2014. This money can then be used to pay for eligible medical and prescription expenses, helping you satisfy your deductible. It can also be used toward eligible dental expenses.
- If you enroll in Plan Option C and elect a Flexible Spending Account (FSA), your FSA dollars will be used first. Once your FSA has been used up, you can then start using your HRA dollars. This process will be automatically administered by AmeriFlex, so you only have to manage one debit card!
- Please note that you are able to use your FSA dollars for all qualified tax dependents, even if they are not enrolled as your dependents on Plan Option C.
- Both FSA and HRA dollars must be used up prior to the end of each plan year. Account balances do not roll over from year to year.

What are the differences between Option A, Option B and Option C if I see a Specialist?

<table>
<thead>
<tr>
<th>Specialist Charge—$150 Allowed</th>
<th>Option A Blue Choice</th>
<th>Option B Blue Options</th>
<th>Option C HDHP/HRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$500</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Applied to Deductible</td>
<td>$150</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Paid by Member</td>
<td>$150</td>
<td>$150</td>
<td>$0</td>
</tr>
<tr>
<td>Paid from HRA</td>
<td>n/a</td>
<td>n/a</td>
<td>$150</td>
</tr>
</tbody>
</table>

What is an Option 1 and Option 2 Facility?

Plan Option B has varying copays and coinsurance for inpatient and outpatient hospital services. Option 1 Hospitals have a $600 co-pay and Option 2 Hospitals have a $900 co-pay. Option 1 and Option 2 facilities are listed below.

**Plan Option B—Blue Options Network Blue Hospitals in Northeast Florida**

- **Option 1 Hospitals** - Flagler Hospital, Baptist Hospitals, Memorial Hospital, St. Vincent’s, St. Luke’s, Wolfson Children’s Hospital, Mayo Clinic Florida Hospital.
- **Option 2 Hospitals** - Shands Jacksonville Medical Center, Shands Hospital at the University of Florida.

Qualifying Events

A **qualifying event**, also known as a “Family Status Change,” is a change in your personal life that may impact you or your dependents’ eligibility for benefits under the St. John’s County Self-Funded Medical Plan. Qualifying events include, but are not limited to marriage, divorce or legal separation, death of spouse or other dependent, birth or adoption of a child, change in child’s dependent status, or change in spouse’s benefits or employment. Please note that your qualified status change must be consistent with the event. You must enroll online within 30 days of all qualifying events.

The plans referenced in this booklet are controlled by various insurance contracts and all final benefit interpretations will be controlled by the various insurance carriers. This information is intended to be a summary of plan provisions. Please reference plan materials for more detail.
## MEDICAL PLANS

Administered by Florida Blue • Customer Service Line: 1.800.352.2583 • Website: www.floridablue.com

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Option A Blue Choice PPO</th>
<th>Option B Blue Options PPO</th>
<th>Option C Blue Options HDHP/HRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost Sharing Options</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible (CYD) (Eff. 1/1/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Individual / Family Aggregate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$500 / $1,500</td>
<td>$500 / $1,500</td>
<td>$1,500 / $3,000</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$500 / $1,500</td>
<td>$500 / $1,500</td>
<td>$3,000 / $6,000</td>
</tr>
<tr>
<td>Coinsurance (Florida Blue / Member)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>80% / 20%</td>
<td>80% / 20%</td>
<td>80% / 20%</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>60% / 40%</td>
<td>60% / 40%</td>
<td>60% / 40%</td>
</tr>
<tr>
<td>Out of Pocket Maximum (Eff. 1/1/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Individual / Family Aggregate</td>
<td>Includes CYD, Coinsurance, Copayments &amp; Rx $3,000 / $9,000</td>
<td>Includes CYD, Coinsurance, Copayments &amp; Rx $3,000 / $9,000</td>
<td>Includes CYD, Coinsurance, Copayments &amp; Rx $4,500 / $9,000</td>
</tr>
<tr>
<td>In-Network</td>
<td>$20 Copayment</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$100 copayment</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Office Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network Family Physician (Pediatrician/ General Practitioner/Internist/Family Doctor)</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>In-Network Specialist (no referral needed)</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Out-of-Network Provider</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Employer Annual HRA Contribution</td>
<td>$0</td>
<td>$0</td>
<td>$600</td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Facility</td>
<td>CYD + coinsurance</td>
<td>Option 1 / Option 2: $600 / $900</td>
<td>Option 1 / Option 2: $500 PAD + CYD + coinsurance</td>
</tr>
<tr>
<td>In-Network</td>
<td>$200 + CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>CYD + coinsurance</td>
<td>Option 1 / Option 2: $150 / $250</td>
<td>Option 1 / Option 2: $150 / $250</td>
</tr>
<tr>
<td>In-Network</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Emergency Room Facility</td>
<td>CYD + coinsurance</td>
<td>$100 copayment</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>In-Network</td>
<td>$20 copay</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>CYD + coinsurance</td>
<td>$20 copay</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Additional Benefits and Features</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgical Center Facility</td>
<td>CYD + coinsurance</td>
<td>$100 copayment</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>In-Network Facility</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Out-of-Network Facility</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Independent Clinical Lab</td>
<td>CYD + coinsurance</td>
<td>$0—Quest Diagnostics</td>
<td>CYD</td>
</tr>
<tr>
<td>In-Network Facility</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Out-of-Network Facility</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Independent Diagnostic Testing Facility</td>
<td>CYD + coinsurance</td>
<td>$100 copayment</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Physician-Administered Medications</td>
<td>CYD + coinsurance</td>
<td>$100 copayment</td>
<td>CYD + coinsurance</td>
</tr>
<tr>
<td>Monthly Out-of-Pocket Maximum</td>
<td>No maximum</td>
<td>No maximum</td>
<td>$200</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammograms (member cost)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Wellness (CYD is waived)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Colonoscopy (Routine for age 50+)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Calendar Year Maximum Per Insured</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>22 visits</td>
<td>20 visits</td>
<td>20 visits</td>
</tr>
<tr>
<td>Mental Health (Inpatient / Outpatient)</td>
<td>30 days / 20 visits</td>
<td>30 days / 20 visits</td>
<td>30 days / 20 visits</td>
</tr>
<tr>
<td>Outpatient Therapy and Spinal Manipulations</td>
<td>35 visits</td>
<td>35 visits</td>
<td>35 visits</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>60 days</td>
<td>60 days</td>
<td>60 days</td>
</tr>
<tr>
<td>Substance Dependency Care and Treatment</td>
<td>10 days / 10 visits</td>
<td>10 days / 10 visits</td>
<td>10 days / 10 visits</td>
</tr>
<tr>
<td>Lifetime Maximum Per Insured</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Per Insured</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Hospice</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

UBI 5229 / 2014 benefits
Beginning January 1, 2014, Rx copays will be applied to the medical plan out-of-pocket maximum for all three plans.

### PRINCIPAL PHARMACY PROGRAM:

Injectable Therapies are used for several chronic disease states such as HIV/AIDS, Rheumatoid Arthritis, Cancer, Hemophilia, Deep Vein Thrombosis, Hepatitis B and C, RSV and Multiple Sclerosis. Injectable Therapy prescriptions are subject to 80/20 coinsurance until the $500 maximum out-of-pocket limit is met. After the maximum is met, normal co-pays apply. Coverage for these therapies are provided through the Caremark SPECIALTY PHARMACY PROGRAM. To begin using Specialty Pharmacy Program, you or your physician should call 1.866.278.5108.

### RETAIL 90 PROGRAM:

You can now get up to a three-month supply of a covered prescription drug (except Specialty Drugs) purchased at a retail Participating Pharmacy! These participating pharmacies are contracted to provide eligible members an extended supply of most commonly prescribed maintenance medications. Once your doctor has determined a medication to be the appropriate maintenance medication for your diagnosed condition, you should ask your doctor to write the prescription for a 90 day supply with any additional refills. Pharmacies that offer this service in the Duval/St. Johns/Flagler County areas include:

- A-1
- AHF
- Azalea Health
- Baptiste
- Baygreen
- Costco
- Florida Specialty
- North Florida Pharmacy of Keystone
- Owens
- Park and King
- Publix
- St Johns Smart
- Target
- Wal-Mart
- Waigreens
- Well Health Rx
- Walgreens
- A-1
- AHF
- Azalea Health
- Baptiste
- Baygreen
- Costco
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- Publix
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- Waigreens
- Well Health Rx
- Walgreens
- A-1

### VISION

Administered by Florida Blue

**GENERAL PROVISIONS**

- $250.00 per Calendar Year Maximum; Deductible is WAIVED for Vision.
- Employee will be responsible for 20% of the charged amount up to the $250 maximum.
- Employee will be responsible for 100% of any charge over the $250 maximum.

**GO ANYWHERE!***

The routine vision plan, offered by Florida Blue, allows it's members to choose any provider, in- or out-of-network, for their vision needs. If you go out-of-network, you will need to submit a claim form to Florida Blue for reimbursement.

**Ask for Vision Discounts!**

*By going to a non-participating provider, you may be balance billed.

Please note: Non-prescription sunglasses are not covered.
HOW TO FIND A DOCTOR AND MORE

The Florida Blue website (www.floridablue.com) is a quick and easy tool to help you confirm whether a specific doctor or dentist is in your plan’s network, or if you want to find a new in-network doctor or specialist in your area that is in your network. **Never rely on your medical or dental provider to tell you whether you are in— or out-of-network. Always make sure to check the online provider directory before each appointment.** On the website’s home page, just click on “Find a Doctor and More” (toward the middle of the page). Once your search results appear, there is a column labeled **Plans Accepted**, which lists which Florida Blue plans each doctor accepts. The plans are designated by their networks. Blue Choice will be listed as the **Preferred Patient Care (PPO)** and Blue Options will be listed as **Network Blue**.

KNOW BEFORE YOU GO!

**Compare Your Choices When It Comes to Medical Services and Prescriptions**

- **You Have Choices When It Comes to the Cost of Your Health Care.**
  - Shop, compare and estimate your medical costs
  - The quality and price of medical services can vary depending on where you go for office visits, imaging services, and surgery, including inpatient and outpatient care.
  - Compare quality and cost before you go, and then decide what’s best for your care.
  - Cost estimates are based on your plan and where you stand with your deductible.
  - Your costs are lower after your deductible is met—pay only coinsurance or a copay for in-network services.
  - You could save hundreds of dollars or more on your health care services!

- **Not All Medications Are Alike. Know Before You Go to the Pharmacy.**
  - Is my prescription drug covered? If not, discounts may be available through our BlueSaver program.
  - Is an authorization required first? If so, your doctor will need to submit a Prior Authorization form.
  - Is a limited quantity covered per prescription? If so, your plan will cover up to the 1 month maximum, and you can pay for more.
  - Is this a brand name drug? Ask your doctor or pharmacist if there’s a generic available that’s right for you.
  - Is this drug in the Step Therapy program? If so, ask your doctor about the alternative drugs that must be tried first
  - Is this an oral or injectible Specialty drug? Specialty drugs require prior authorization and must be obtained through Caremark Specialty Pharmacy at 1-866-387-2573.
  - Is this a diabetic supply? Supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/or syringes require a prescription that you can fill at your local pharmacy.
  - Is this a drug that you take ongoing? Order up to a 3-month supply and pay less than monthly refills.

**You have two easy ways to compare.**

Go to floridablue.com to login/register on My Blue Service. Once you login, under **Know Before You Go**, click **Compare Medical Costs** or **Compare Drug Prices**.

Call a Care Consultant 1-888-476-2227. Their team is available to assist you in getting the right care by providing care referrals, clinical support, social and community resources, and financial assistance.

YOUR BENEFITS TRAVEL WITH YOU!

When you’re a FloridaBlue member, you take your healthcare benefits with you—across the country and around the world. The BlueCard Program gives you access to doctors and hospitals almost everywhere, giving you the peace of mind that you’ll be able to find the healthcare provider you need. Within the United States, you’re covered whether you need care in urban or rural areas. Outside of the United States, you have access to doctors and hospitals in nearly 200 countries and territories around the world through the BlueCard Worldwide® Program.

Take charge of your health, wherever you are:

1) Always carry your current Florida Blue ID card;
2) In an emergency, go directly to the nearest hospital;
3) To find nearby doctors and hospitals, call BlueCard Access® at 1.800.810.BLUE (2583) or visit http://provider.bcbs.com/;
4) Call your Blue Plan for precertification or prior authorization, if necessary. The phone number is located on your ID card, and;
5) When you arrive at the participating doctor’s office or hospital, show the provider your ID card.
What is a Flexible Spending Account (FSA)?
- An FSA is an IRS regulated Section 125 plan which allows you to have money deducted from your paycheck before taxes are determined and deposited into an account that you can use for unreimbursed medical expenses or dependent daycare expenses.

**WHAT ARE THE BENEFITS OF AN AMERIFLEX FSA?**
- NO taxes on the amount(s) that are deducted from your paycheck and deposited to your FSA account!
- Top of the line Online services at http://www.flex125.com! Track your FSA account online!
- Accelerate personal cash flow!
- Eliminate paper claims!
- Achieve immediate reimbursement through your FSA card without sending in receipts!
- Reduce lost and unfiled claims!
- Pay for Dependent Day Care with the same card you use for Medical FSA!!!
- Order your pharmacy items through the AmeriFlexRX online drug store TAX FREE with FREE SHIPPING!

What are some examples of eligible unreimbursed medical expenses?*
- Your annual medical and dental plan deductibles
- Your annual medical, dental and vision co-insurance expenses
- Prescription co-pays
- Mileage for medical, dental and vision appointments
- Any IRS approved Medical Expense in accordance with IRS publication 502 even if it is not covered under the medical or dental plans

What are eligible dependent daycare expenses?
- Daycare for children under the age of 13
- Disabled spouses
- Dependent parents

How will I access the money that has been deposited into the FSA?
- FSA debit card (as pictured above)
- Paper claim form (for all over-the-counter medicines for which a prescription is required) and when a card reader is not present

Over-the-counter (OTC) rules
- Expenses incurred for the following OTC medicines/drugs (with the exception of insulin) will not be eligible for reimbursement without a prescription:
  - Antacids, allergy and sinus medications, anti-diarrheals, anti-gas, anti-itch and insect bites, baby rash ointments and creams, cold sore remedies, cough, cold and flu medications, digestive aids, feminine anti-fungal/anti-itch, laxatives, motion sickness medications, pain relievers, respiratory treatments, sleep aids and sedatives, stomach remedies.
  - You are required to file a paper claim form in order to be reimbursed for all OTC medicines for which a prescription is required
  - OTC items which are not considered a medicine or drug will not require a prescription and therefore, you will still be able to use your debit card to pay for these items at a pharmacy/drug store, just as you have in the past:
    - Acne creams, anti-fungal foot medication, antiseptics and wound cleaners, band aids, braces and supports, catheters, denture adhesives, diabetic testing and aids, diagnostic tests and monitors, elastic bandages and wraps, eye care and contact lens supplies, family planning kits, fiber laxatives, first aid supplies, hearing aid batteries, infant electrolytes and dehydration solutions, infant teething pain supplies, insulin and diabetic supplies, nebulizers, orthopedic aids, ostomy products, reading glasses, smoking deterrents, syringes, thermometers, wheelchairs, walkers and canes.

What is the maximum that I can deposit into each account each year?
- Unreimbursed Medical FSA - $2,500
- Dependent Day Care FSA - $5,000

How do I elect to participate in the FSA plans?
- Each year you must enroll online for the FSA and state the annual amount you elect to contribute for the calendar year (January 1 - December 31).

What if I do not use all of the funds that are in my FSA account(s)?
**Plan Carefully! If you do not use the funds by the end of the year you will lose the funds.** The funds will not roll over to your account for the next year. For example, 2014 funds will not roll over to 2015. They will remain in the general FSA account to be used for administrative purposes. If you are planning on having a procedure done in 2014, such as LASIK, please make sure you are approved for the procedure prior to electing your annual deposit, so that you do not over-elect and lose the funds! Please note that this is an IRS regulation.

*Even though your reimbursement is automatic, you may be required to submit receipts that clearly substantiate eligible reimbursements under FSA. This substantiation is required by the Internal Revenue Service.

**HOW CAN I LEARN MORE ABOUT FLEXIBLE SPENDING ACCOUNTS?** Go to your benefits website, www.sjcbcc.benergy.com to view a short, informative video, provided by your FSA carrier, AmeriFlex. Select the drop down menu labeled “Benefits,” choose “Work-Life,” and then click “Flexible Spending Accounts.” Under Find Out More, click on “FSA Enrollment Presentation.”
What is a Health Reimbursement Account?
A Health Reimbursement Account (HRA) is an employer-funded account that is designed to reimburse employees for qualified medical expenses that are paid for out-of-pocket. HRAs are often designed to operate with a high deductible health plan (HDHP), thereby reducing premium costs while encouraging employees to spend wisely.

Who is eligible for an HRA?
All benefits-eligible employees who enroll on Option C—the Blue Options High Deductible Health Plan—will automatically be set up with a Health Reimbursement Account. An HRA may reimburse medical care expenses only if they are incurred by employees and their spouses and tax dependents who are enrolled on the medical plan. HRA coverage must be in effect at the time the expense is incurred.

What if I am enrolled in the HRA and also elect to participate in an FSA?
Employees can contribute to an FSA while enrolled in the HRA. You can contribute the full $2,500 to your FSA in addition to receiving the $600 contribution from St. Johns County into your HRA. Please note that you will be required to use your entire FSA balance prior to accessing the $600 St. Johns County HRA contribution. PLAN CAREFULLY! For example, if you elect both a medical FSA and Medical Plan Option C (HDHP with HRA) and originally planned on contributing $2,500 to your medical FSA in 2014, you may only want to contribute $1,900 to your FSA, utilizing the $600 HRA contribution to add up to $2,500.

What is a High Deductible Health Plan (HDHP)?
The St. Johns County HDHP has:
- A higher annual deductible than typical health plans;
- A maximum limit on the sum of the annual deductible and out-of-pocket covered medical expenses that you must pay; and
- Preventive benefits covered at 100%, without having to first meet your deductible.

Are HRAs really best only for the young and healthy?
No. HRAs and other HDHPs are well-suited for a very wide demographic of people. According to a recent carrier survey, the average age of HRA plan members is 42, the same average age as those who opted for more traditional plans.

Contributions to your HRA
St. Johns County sets up and funds the account, so it costs you nothing out-of-pocket. St. Johns County will contribute $600 annually to each employee’s HRA.

What are some examples of qualified medical expenses?
Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. Examples include amounts paid for doctors’ fees, prescription medicines and necessary hospital services not paid for by insurance. You can use your HRA funds for deductibles, copayments and coinsurance.

What if I have a balance in my HRA at the end of the year?
HRA dollars must be used up prior to the end of each plan year. Account balances do not roll over from year to year.

What if I terminate my employment during the Plan Year?
If you cease to be an Eligible Employee, your participation in the HRA Plan ends unless you elect COBRA continuation coverage. You will be reimbursed for any medical care expenses incurred prior to your termination date, up to your account balance in the HRA, provided that you comply with the plan reimbursement request procedures required under the plan. Any unused portions will be unavailable after termination of employment. The rules regarding COBRA are contained within your Summary Plan Description.

What is the difference between an HRA and FSA?
HRAs are employer-funded, which means your employer determines the amount that goes into the HRA account. FSAs are employee-funded, which means the funds are deducted from your salary. You determine the amount to go into your FSA account.

Are my benefits taxable?
The HRA plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA Plan generally are not taxable to you. Your employer cannot guarantee the tax treatment to any given participant, since individual circumstances may produce differing results.

What does the IRS require me to report on my taxes concerning my HRA?
Nothing. Your HRA is a health benefit.
You want to do your best on the job. But when you have something on your mind, it can affect your work as well as your home life. The way you feel affects the way you work, so we want you to have someone to turn to when you need help.

No one will know you are using the EAP unless you tell them. HIPAA regulations for confidentiality are strictly followed. You must sign a Release of Information before your counselor is allowed to communicate any information, except by those situations required by law when there is a danger to self or others.

The goal of the Employee Assistance Program (EAP) is to help you restore your balance. New Directions Behavioral Health can help you achieve your goals through the right information and short-term counseling. The EAP provides you with four free face-to-face visits, as well as referrals to legal, financial, child and elder care resources, which give you even more resources to keep work and life balanced. Keep in mind that services are confidential. No one will know you’ve called EAP.

The New Directions Resource Center is answered live 24 hours a day, 7 days a week for your convenience. You and your family can call for assistance with:

- Stress at home or on the job
- Questions about healthy lifestyle
- Attorney referrals for legal needs
- Financial needs such as budgeting
- Parenting concerns
- Aging and retirement
- Drugs and alcohol
- Depression and anxiety
- Conflicts and communication
- Help with problem solving
- Support during difficult life events

New Directions Behavioral Health has over 25 years experience helping employers and employees reach their goals. Services include:

- 24/7 Resource Center
- Assessment of individual problems
- Referrals to behavioral health and community resources
- Orientation and program promotion
- Telephone and video consultation
- Short-term counseling
- Training for supervisors and employees
- Formal management referral
- Crisis management
- Work/Life programs

To access the Employee Assistance Program, call 1-800-624-5544. Or, go to www.ndbh.com—your company passcode is SJCFL.

ACCIDENT INSURANCE

Administered by Chartis

- Provides in the line-of-duty coverage for full-time firefighters and EMTs of St. Johns County only, in accordance with Florida Statutes
- A $65,000 benefit will be paid for Covered Employees who are:
  - Accidentally killed or receive bodily injury which results in the Employee’s death or dismemberment
  - Accidentally dismembered or killed while responding at the time of injury, in fresh pursuit, to an emergency or traffic accident
- A $185,000 benefit will be paid for Covered Employees who are unlawfully and intentionally dismembered or killed by another or receive bodily injury which is unlawfully and intentionally inflicted upon Employee by another and which results in the Employee’s death or dismemberment.
- Additional benefits include funeral & burial, continuation of medical coverage for eligible family members, educational and spouse retraining, and daycare.
Employees may elect an amount of Optional Life Insurance in $10,000 increments, with a Maximum Benefit of $500,000.

You may elect Spouse Optional Term Life in increments of $5,000 up to $150,000.

Your life insurance election can be up to 100% of your spouse’s amount.

You may elect coverage for your child(ren); in $2,000 increments up to $10,000.

<table>
<thead>
<tr>
<th>Class</th>
<th>Amount*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elected Officials &amp; Senior Management</td>
<td>$50,000</td>
</tr>
<tr>
<td>All Other Eligible Employees (Amount reduces every 5 years starting at age 65)</td>
<td>$20,000</td>
</tr>
<tr>
<td>Eligible Spouses (if dependent on health policy)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Eligible Child(ren) (if dependent on health policy)</td>
<td>$2,000</td>
</tr>
<tr>
<td>All Eligible Retirees</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

*This benefit also includes waiver of premium, 75% accelerated death benefit, and conversion.

Value-Added Services:

All full-time benefit eligible employees have access to the following programs with Sun Life:

- **Emergency Travel Assistance**—If an employee or his/her family is traveling more than 100 miles away from home and has a medical or personal emergency, help is just a phone call away. Employees can receive assistance with emergency medical evacuation, lost prescription assistance, family or friend compassionate visit for those traveling alone and expecting to be hospitalized for more than 7 days, and much more.

  **Call Assist America at 1-800-872-1414 within the U.S. or 1-301-656-4152 outside the U.S.**

- **Identity Theft Protection**—This service, provided by Assist America, provides 24/7 telephone support and guidance by anti-fraud experts, a dedicated expert caseworker who will help notify credit bureaus, file paperwork to correct credit reports, cancel stolen cards, and request new ones, and more!

  **If you have been a victim of identity theft, or to register your cards, call 1-877-409-9597.**

Optional Term Life Insurance

SPECIAL ENROLLMENT OPPORTUNITY DURING THE MONTH OF OCTOBER!

If you previously waived coverage or elected less than the guaranteed issue amount, you are able to purchase up to $300,000 of voluntary life insurance on yourself and up to $25,000 on your spouse, without having to complete Evidence of Insurability (EOI)!

This opportunity is only available during Open Enrollment in October 2013. All changes will take effect January 1, 2014.

**Employee / Spouse**

<table>
<thead>
<tr>
<th>Age</th>
<th>Monthly Cost per $1,000 of Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$0.07</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.08</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.11</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.17</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.31</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.47</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.70</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.01</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.50</td>
</tr>
<tr>
<td>70+</td>
<td>$2.74 (employee only)</td>
</tr>
</tbody>
</table>

*All Eligible Children are $0.24 per $2,000 of Coverage.

*Rates increase every 5 years.

- Employees may elect an amount of Optional Life Insurance in $10,000 increments, with a Maximum Benefit of $500,000.
- You may elect Spouse Optional Term Life in increments of $5,000 up to $150,000.
- Your life insurance election can be up to 100% of your spouse’s amount.
- You may elect coverage for your child(ren); in $2,000 increments up to $10,000.

Remember to update your beneficiaries online at anytime!
A long-term disability (LTD) plan is designed to replace part of your income in the event of disabling injuries or sickness, whether it occurs on or off the job. LTD plan benefits generally begin after an elimination period and will assist you in maintaining your normal lifestyle.

**Benefit Amount**

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>60% of Total Monthly Earnings not to exceed a maximum of $5,000</td>
<td></td>
</tr>
</tbody>
</table>

**Elimination Period**

(period of time between an injury/illness and benefit payment)

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>180 Days</td>
<td></td>
</tr>
</tbody>
</table>

**Benefit Period**

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 60</td>
<td>To age 65 or your normal Retirement Age under Social Security</td>
</tr>
<tr>
<td>60</td>
<td>60 Months</td>
</tr>
<tr>
<td>61</td>
<td>48 Months</td>
</tr>
<tr>
<td>62</td>
<td>42 Months</td>
</tr>
<tr>
<td>63</td>
<td>36 Months</td>
</tr>
<tr>
<td>64</td>
<td>30 Months</td>
</tr>
<tr>
<td>65</td>
<td>24 Months</td>
</tr>
<tr>
<td>66</td>
<td>21 Months</td>
</tr>
<tr>
<td>67</td>
<td>18 Months</td>
</tr>
<tr>
<td>68</td>
<td>15 Months</td>
</tr>
<tr>
<td>69 and over</td>
<td>12 Months</td>
</tr>
</tbody>
</table>

**SHORT-TERM DISABILITY**

Provided by St. Johns County • Administered by Sun Life • www.sunlife.com/us or www.securassit.com/sunlife/

SPECIAL OPPORTUNITY! During 2013 Open Enrollment only, you can enroll in Short-Term Disability coverage with no medical questions asked, guarantee issue! This opportunity is available to all employees, even if you previously waived coverage when first eligible for benefits.

Short-Term Disability (STD) coverage protects you when an illness, accident or maternity leave has kept you out of work. This coverage will continue to pay you 60% of your weekly pay.

**two plans to choose from:**

**OPTION 1** - PAYS AFTER 14 DAYS & UP TO 24 WEEKS OF A DISABILITY

**OPTION 2** - PAYS AFTER 30 DAYS & UP TO 22 WEEKS OF A DISABILITY

- Available to all employees working 30 hours or more per week
- Weekly benefit is 60% of your weekly salary
- Maximum benefits are $1,000 per week
- Coverage is employee paid; rates are based on your age and weekly pay. Subject to increase with salary increases.
- STD coverage is contributory, meaning that you are responsible for paying your premium through payroll deduction. In order to see your per pay period rate, go online to www.sjcbcc.benergy.com.
- If you were treated for any condition in the 3 months prior to your STD coverage going into effect, any resulting disability related to your initial treatment will not be covered for up to 12 months.
- You may use accrued sick leave or vacation while receiving STD benefits but the combination of STD benefits and sick or vacation time will not exceed 100% of pre-disability earnings.

**MONTHLY RATES PER $10 OF COVERED BENEFIT**

<table>
<thead>
<tr>
<th>Age</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.67</td>
<td>$0.53</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.83</td>
<td>$0.65</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.61</td>
<td>$0.48</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.60</td>
<td>$0.47</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.69</td>
<td>$0.54</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.81</td>
<td>$0.64</td>
</tr>
<tr>
<td>50-54</td>
<td>$1.01</td>
<td>$0.80</td>
</tr>
<tr>
<td>55-59</td>
<td>$1.38</td>
<td>$1.09</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.91</td>
<td>$1.51</td>
</tr>
<tr>
<td>65-69</td>
<td>$2.98</td>
<td>$1.56</td>
</tr>
<tr>
<td>70+</td>
<td>$2.02</td>
<td>$1.59</td>
</tr>
</tbody>
</table>

Premiums are automatically calculated online.
To Logon to Benergy: Enter your User ID and Password. Your User ID is the first initial—last name—last 4 digits of your Social Security number (SS#). (For example: jdoe3333 Please note that this cannot be longer than 13 characters so if your last name has more than 8 letters, just use the first 8 letters of your last name). Your password is one that you have created. If you do not remember your password, e-mail tfarrow@sjcfl.us.

Attention New Employees!
Click on View a Life Event and choose New Hire Enrollment link to enroll in your benefits!

**Ready to Enroll for 2014?**
It is easy to get started...Go to Ready Enroll Online Enrollment at www.sjcbcc.benergy.com

**To Logon to Benergy:** Enter your User ID and Password. Your User ID is the first initial—last name—last 4 digits of your Social Security number (SS#). (For example: jdoe3333 Please note that this cannot be longer than 13 characters so if your last name has more than 8 letters, just use the first 8 letters of your last name). Your password is one that you have created. If you do not remember your password, e-mail tfarrow@sjcfl.us.

**Attention New Employees!**
Click on View a Life Event and choose New Hire Enrollment link to enroll in your benefits!

**Online Enrollment**

**Benefits**
> Health. Review your medical, dental, vision and prescription benefits.
> Income Protection. Review information on the life insurance and AD&D and both short- and long-term disability.
> Work/Life. Look up information on the flexible spending account.
> There are also financial calculators, event checklists and informative articles on a wide array of topics.

**My Info**
> Personal Health Record. Create personal health records, where you can organize details about you and your family’s doctors, immunizations, tests and more. This information is secure and for your eyes only.
> My Benefits. Review past elections or update your address and/or beneficiary.
IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St. Johns County 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. St. Johns County has determined that the prescription drug coverage offered by the St. Johns County Self-Funded Medical Plan & Prime Therapeutics is, on average for all 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 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current St. Johns County Self-Funded Medical Plan prescription coverage will be affected. You can not keep your coverage with St. Johns County if you elect Part D coverage. If you decide to join a Medicare drug plan and drop your current coverage under the St. Johns County Self-Funded Medical Plan, be aware that you and your dependents will not be able to get this coverage back. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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 prescription drug coverage with the St. Johns County Self-Funded Medical Plan 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 the 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 November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact your Personnel Department. 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 with Prime Therapeutics 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.

REMEMBER: Keep this Creditable Coverage notice. If you decided 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). 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).

Date: January 1, 2014
Name of Entity/Sender: St. Johns County
Contact/Position: Rachael Lando, Account Executive, The Bailey Group
Address: 1200 Plantation Island Drive, Suite 210, St. Augustine, FL 32080
Phone Number: (904) 461-1800
Notice to Employees in a Self-Funded Nonfederal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. St. Johns County has elected to exempt the St. Johns County Self-Funded Medical Plan from the following requirements:

Parity in the application of certain limits to mental health benefits
Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan. This basically means that your current mental health and substance abuse benefits provided under the St. Johns County Self-funded Medical Plan will not be changed. The exemption from these Federal requirements will be in effect for the 2014 Plan Year beginning 1/1/2014 and ending 12/31/2014. The election may be renewed for subsequent plan years. HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer’s health plan, or if you wish to purchase an individual health insurance policy. If you have any further questions, please contact Rachael Lando at The Bailey Group at 904-461-1800.

Women’s Health & Cancer Rights Act of 1998 (WHCRA) Model 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: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) prostheses; and 4) 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 your Plan Administrator, Florida Blue, at 1.800.352.2583.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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, 2013. You should contact your State for further information on eligibility:

FLORIDA – Medicaid Website: https://www.fmlmedicaidtpi.com/ Phone: 1-877-357-3268
UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the health plan that compiled it. However, you have certain rights with respect to the information. You have the right to:

- Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
- Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. We reserve the right not to agree to a given requested restriction.
- Request to receive communications of protected health information in confidence.
- Inspect and obtain a copy of the protected health information contained in your medical or billing records and in any other of the organization’s health records used by us to make decisions about you.
- Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
  - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
  - is not part of your medical or billing records;
  - is not available for inspection as set forth above; or
  - is accurate and complete.
  In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
- Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
  - to carry out treatment, payment and health care operations as provided above;
  - to persons involved in your care or for other notification purposes as provided by law;
  - to correctional institutions or law enforcement officials as provided by law;
  - for national security or intelligence purposes;
  - that occurred prior to the date of compliance with privacy standards (April 14, 2003 or April 14, 2004 for small health plans);
  - incidental to other permissible uses or disclosures;
  - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
  - made to plan participant or covered person or their personal representatives;
  - for which a written authorization form from the plan participant or covered person has been received.
- Revoke your authorization to use or disclose health information except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
- Receive notification if affected by a breach of unsecured PHI.
This organization may use and/or disclose your medical information for the following purposes:

**Treatment:** We may use or disclose your health information without your permission for health care providers to provide you with treatment.

**Payment:** We may use or disclose your health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. Such functions may include reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

**To Carry Out Certain Operations Relating to Your Benefit Plan:** We also may use or disclose your protected health information without your permission to carry out certain limited activities relating to your health insurance benefits, including reviewing the competence or qualifications of health care professionals, placing contracts for stop-loss insurance and conducting quality assessment activities.

**To Plan Sponsor:** Your protected health information may be disclosed to the plan sponsor as necessary for the administration of this health benefit plan pursuant to the restrictions imposed on plan sponsors in the plan documents. These restrictions prevent the misuse of your information for other purposes.

**Health-Related Benefits and Services:** We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your protected health information for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing health plan coverage, and about health-related products and services that may add value to your existing health plan.

**Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

**Business Associates:** There may be some services provided in our organization through contracts with Business Associates. An example might include a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

**Limited Data Sets:** We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets. These circumstances include public health, research, and health care operations purposes.

**Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Worker's Compensation:** We may release protected health information about you for programs that provide benefits for work related injuries or illness.

**Communicable Diseases:** We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities:** We may disclose protected health information to federal or state agencies that oversee our activities.

**Law Enforcement:** We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

**Military and Veterans:** If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

**Lawsuits and Disputes:** We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

**Abuse or Neglect:** We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Coroners, Medical Examiners, and Funeral Directors:** We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

**Public Health Risks:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

**Serious Threats:** As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Food and Drug Administration (FDA):** As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**For Purposes For Which We Have Obtained Your Written Permission:** All other uses or disclosures of your protected health information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.
INFORMATION WE COLLECT ABOUT YOU

We collect the following categories of information about you from the following sources:

- Information that we obtain directly from you, in conversations or on applications or other forms that you fill out.
- Information that we obtain as a result of our transactions with you.
- Information that we obtain from your medical records or from medical professionals.
- Information that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other insurance-related needs.

GENETIC INFORMATION

We will not use genetic or disclose genetic information or results from genetic services for underwriting purposes, such as:

- Rules for eligibility or benefits under the health plan;
- The determination of premium or contribution amounts under the health plan;
- The application of any pre-existing condition exclusion under the health plan; and
- Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY FOR E-MAIL COMMUNICATION

If you choose to communicate with us via e-mail, please be aware of the following due to the nature of e-mail communication: (a) privacy and security of e-mail messages are not guaranteed (b) we are not responsible for loss due to technical failures and (c) e-mail communication should not be used for emergencies or time and content sensitive issues.

POTENTIAL IMPACT OF STATE LAW

In some circumstances, the privacy laws of a particular state, or other federal laws, provide individuals with greater privacy protections than those provided for in the HIPAA Privacy Regulations. In those instances, we are required to follow the more stringent state or federal laws as they afford the individual greater privacy protections. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights.

NOTICE OF PRIVACY PRACTICES AVAILABILITY

You will be provided a hard copy for review at the time of enrollment (or by the Privacy compliance date for this health plan). Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization’s Web site (if applicable Web site exists) for downloading.
FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our HIPAA Privacy Officer, Sarah Taylor, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

St. Johns County Self-Funded Medical Plan
Sarah Taylor
Privacy Officer
500 San Sebastian View
St. Augustine, FL 32084
(904) 827-6886
(904) 827-6887

NOTES
contacts:

MEDICAL PLAN
Administrator:
Florida Blue
PPO Group Number 13902
PO Box 1798
Jacksonville, FL 32231
1.800.352.2583
www.floridablue.com

PHARMACY PLAN
Administrator:
Prime Therapeutics
PO Box 660319
Dallas, TX 75266-0319
1.800.352.2583
www.myprime.com

DENTAL PLAN
Administrator:
Florida Combined Life
Dental Claims Administrator
PO Box 1047
Elk Grove Village, IL 60009-1047
1.888.223.4892

MEDICAL & DEPENDENT CARE
FLEXIBLE SPENDING ACCOUNT &
HEALTH REIMBURSEMENT ACCOUNT
Administrator:
AmeriFlex
1.888.868.FLEX (3539)
1.253.322.6864 Fax

LIFE INSURANCE, LONG-TERM & SHORT-
TERM DISABILITY
Administrator:
Sun Life Financial
SC 2350, One Sun Life Executive Park
Wellesley Hills, MA 02481
1.800.247.6875
www.sunlife.com/us

EMPLOYEE ASSISTANCE PROGRAM (EAP)
Administrator:
New Directions Behavioral Health
4800 Deerwood Campus Parkway
Building 600, 1st Floor
Jacksonville, FL 32246
1.800.624.5544
www.ndbh.com

BOCC PERSONNEL SERVICES
BENEFITS TEAM
500 San Sebastian View
St. Augustine, FL 32084
904.209.0635, Option 5
tfarrow@sjcfl.us
smulligan@sjcfl.us

LOCAL REPRESENTATIVE
Receptionist—1.904.461.1800
Mark Bailey, President of The Bailey Group
Debbie Weiner, Account Executive
Rachael Lando, Account Executive

Toll Free—1.866.826.1800
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www.myprime.com
FCL 888.223.4892
www.floridablue.com
Ameriflex 888.868.3539
www.ﬂex125.com
Sun Life 800.247.6875
www.sunlife.com/us
EAP 800.624.5544
www.ndbh.com (sjcfl)