2019

ST. JOHNS COUNTY benefits GUIDE

For Retirees

PRODUCED BY

Guide Contents

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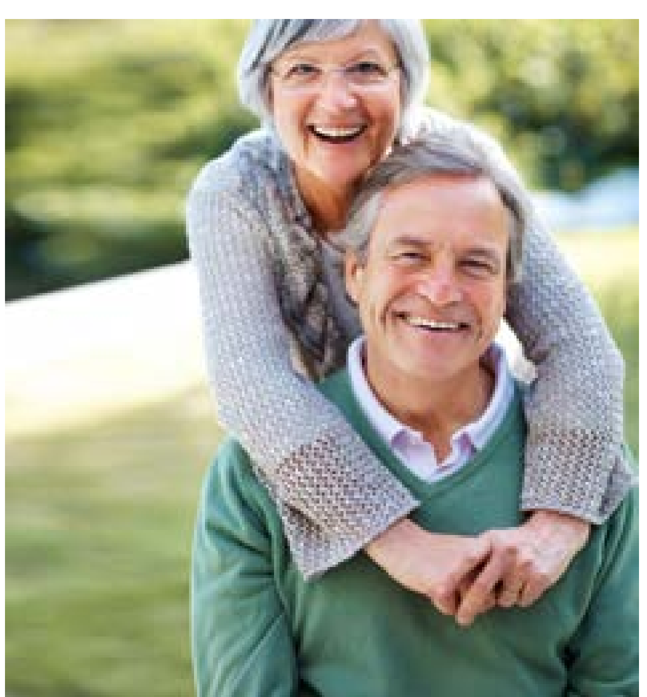
Know the options for you and your family

Take control of your health, income protection, and self

This Benefits Guide provides an overview of the comprehensive retiree benefits package the St. Johns County Board of County Commissioners offers to its retirees and retirees from the St. Johns County Property Appraiser, St. Johns County Tax Collector, St. Johns County Sheriff's Office, St. Johns County Supervisor of Elections and St. Johns County Clerk of Court and Comptroller.

St. Johns County is self-funded for its medical, prescription, and dental coverage. Your premiums which are based on claims incurred in each plan/tier, as calculated by an independent actuary, are kept in a health insurance fund, along with the deposits that St. Johns County contributes toward your health insurance. A third party administrator is used to identify network providers, apply discounts, and pay claims, which are subtracted from the fund.

Please note that if you or your spouse are 65 or over, the St. Johns County Self-Funded Medical Plan requires you to enroll in Medicare Parts A and B. It is your responsibility to advise your benefits department of any change in your Medicare status for yourself and/or your spouse.



This guide will assist you in understanding the various benefits which are available to you effective January 1st through December 31st. You will also learn about the many online tools that are available for managing your benefits, claims, accessing health and wellness information, and exploring discount programs.

Your Open Enrollment period runs from October 1—October 31, 2018. Enrollment elections and changes must be submitted to your Benefits department no later than October 31, 2018.

Note: This benefits guide is to help you choose benefits offered by St. Johns County, and is not representative of all plan provisions or rules. Please refer to each plan document for a full explanation of benefits, which are available from your benefits department. Plan documents and rules prevail if there are any discrepancies with this benefits guide.

What's New for 2019?

Pharmacy Plan Update

Our prescription coverage for 2019 will now be with CVS/Caremark. CVS/Caremark will manage your prescription benefits just like Florida Blue manages your medical benefits. The CVS/Caremark team will ensure that you get the medication you need, when you need it. You can learn more about your Rx benefits, including coverage and spend review, savings, medication costs, in-network pharmacies, refill prescriptions and more at caremark.com or by downloading the mobile app. During the month of December, you will receive new ID cards from CVS for your prescription needs, effective 1/1/2019. You will also be receiving new ID cards from Florida Blue to use for your medical needs.

Reimbursement Account Update

Our Health Reimbursement Account (HRA) is now with Medcom. This new administrator has an excellent customer service team, a robust app for easy claim and receipt submission. All retirees covered under the Reimbursement Account will receive a new debit card for 2019.

Rates

Beginning January 1, 2019, monthly Grandfathered rates on the Blue Options PPO Plan (03559) will increase by 3% on all tiers. Non-grandfathered Under 65 / Over 65 rates on both the Blue Options PPO (03559) and Blue Options HDHP (05360) will increase by 3.2% on all coverage tiers.

Retiree Life Insurance

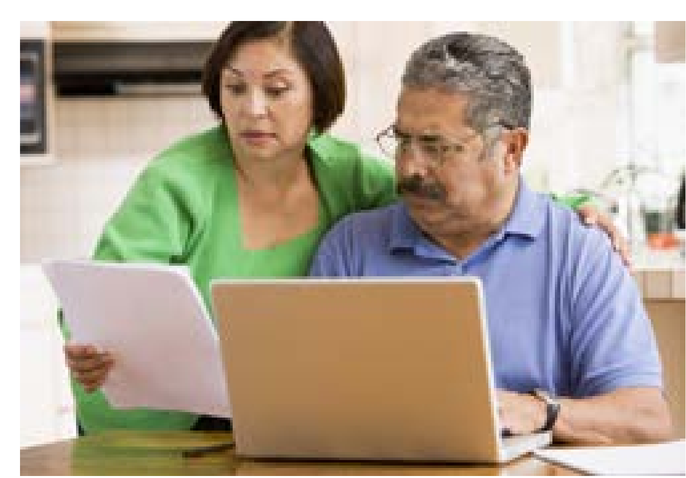
Our Group Life Insurance is now with The Standard. Benefits will remain the same and include additional value-added services, outlined in this benefits guide.

New Open Enrollment Month

Your Open Enrollment period for 2019 benefits has moved to a new month-October 1-31, 2018. You now have the opportunity to make your enrollment elections online through our online enrollment program- Plan Source. Please refer to the "How to Enroll for Benefits" page in this guide for instructions.

Adding an Eligible Family Member?

Documentation is required to add eligible family members to the St. Johns County Health Plan. If documentation is not provided, coverage for the added dependent(s) will be denied. Please provide documentation to your St. Johns County benefits representative with your enrollment forms. You can also upload documents if you are making your enrollment elections online through Plan Source.



Enrolling for Benefits

St. Johns County Retirees have two options to enroll for benefits:

1. Complete and return the Benefits Enrollment Form and Spousal Remittance Form (if applicable) provided by your St. Johns County benefits representative.

2. Complete enrollment online through Plan Source.

Plan Source is the self-service, online portal for retirees to enroll in all benefit plans. Once logged in, you will be able to see benefits offered to you and compare cost.

Current Retirees: Mandatory Annual Open Enrollment is October 1 through October 31. Coverage elected during Annual Open Enrollment becomes effective on January 1.

Log on to https://benefits.plansource.com**.** Username is your first initial of your first name, first six letters of your last name, and last four of social. (Ex. jsmith0410). Your temporary password will be your date of birth in the YYYYMMDD format. **Please note:** Your NEW password must be at least 8 characters long.

Step 1: Review the information and update your personal data.
The * indicates a required field. Remember to press "Continue" at the bottom of the page to proceed through the enrollment and only use the gray Plan Source "Back" button. Do NOT use the back button on your internet browser or your changes will be lost.

Step 2: If you need to add a dependent to your coverage, choose "Add Dependent" on the Update Dependent screen. You should verify/add all dependents, even if you are not enrolling them. If your desired election does not appear, or your dependent is not showing, you must go back to this section and add them.

Step 3: Continue through each screen including benefit offering, choosing your desired election under the appropriate plan, or declining the benefit entirely. If you elect coverage with dependents, check the box next to each dependent you would like to enroll.

Step 4: Upload the required documents if you added any dependents to your coverage.

Step 5: Once you have completed each benefit election, the Confirmation page will appear. Review for accuracy and choose "Confirm" at the bottom of the page. Your benefit election will not be complete until you hit the "Confirm" button.

Life Events:

You may add, drop, or change coverage or dependent coverage outside of Open Enrollment ONLY if you experience a qualifying life event as defined by Internal Revenue Code.

Qualifying life events may include: marriage, divorce, birth, adoption, or a gain/loss of coverage by your spouse or other dependent. It is required that you submit your qualifying life event through Plan Source and all supporting documents within 30 calendar days of any change in status.

PLEASE NOTE: It may take up to 2 weeks for life events to be processed.

Choosing Your Medical Plan

800-352-2583* • *www.floridablue.com

Health insurance is a way to pay for health care and protects you from paying the full costs of medical services when you become injured or sick. You choose a plan and pay a certain rate, or premium, each month. Both plan options, administered by Florida Blue, cover preventive care such as doctor visits and screenings, as well as hospital visits, ER trips, and even prescription drugs.

Do I have to use certain medical providers?

You can see any medical provider you choose, but **cost savings are highest** when you use a participating provider in Florida Blue's network. Both medical plan options use Florida Blue's Blue Options network.

What is the benefit of the Health Reimbursement Account that comes with enrollment in the Blue Options HDHP?

The high deductible health plan (HDHP) offers lower premiums and higher deductibles than the Blue Options PPO plan. Enrolling in the HDHP automatically enrolls you in a Health Reimbursement Account (HRA), a reimbursement plan funded by St. Johns County. The HRA contribution will be pro-rated on a monthly basis for participants whose benefits become effective after January 31.

If you are enrolled in the Blue Options HDHP as of January 1, St. Johns County contributes to your HRA account based on health coverage tiers:

- $600 Retiree Only
- $1,000 Retiree + Spouse
- $1,000 Retiree + Children
- $1,500 Retiree + Family

What are some of the key plan terms I should know before electing a plan?

Calendar Year Deductible (CYD): The amount you pay before the health plan begins to pay for covered services. For example, if your deductible is $1,500, the plan won't pay anything until you meet your deductible for covered health care services that are subject to the deductible.

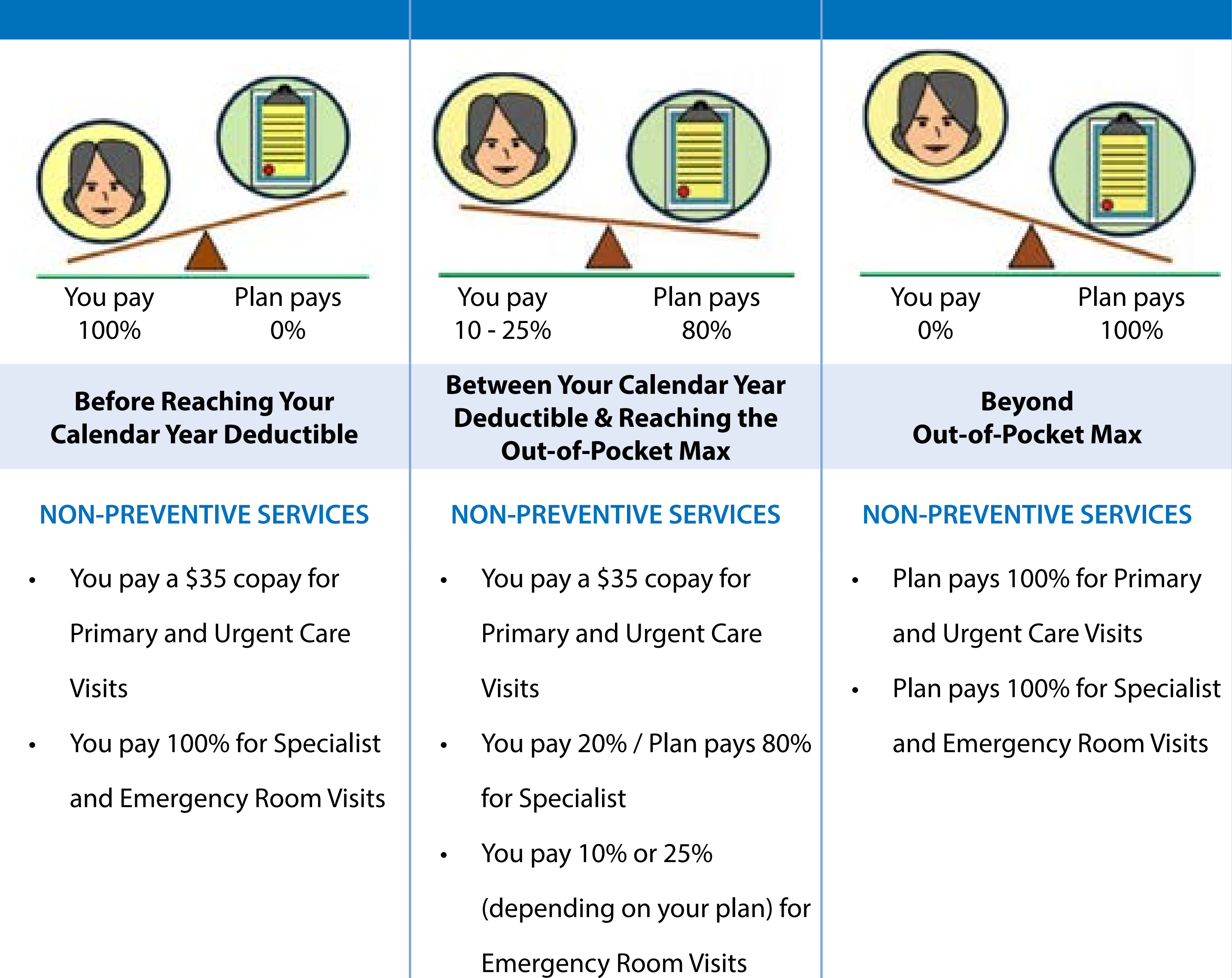
Coinsurance: After you've met the CYD, coinsurance is the cost sharing between you and the plan. For example, with an in-network service, the plan pays 80% and you pay 20% (depending on your plan).

Out of Pocket Maximum: The most you will pay for covered expenses within a calendar year. The maximum never includes your premium or services the plan does not cover.

Copay: A fixed amount you owe at the time of a health care service. Copay amounts do not apply to CYD and you do not need to meet CYD first.

Understanding Your Medical Plan

When you have eligible in-network medical expenses:



Before Reaching Your Calendar Year Deductible	Between Your Calendar Year Deductible & Reaching the Out-of-Pocket Max	Beyond Out-of-Pocket Max
You pay 100% / Plan pays 0%	You pay 10 - 25% / Plan pays 80%	You pay 0% / Plan pays 100%
NON-PREVENTIVE SERVICES	NON-PREVENTIVE SERVICES	NON-PREVENTIVE SERVICES
• You pay a $35 copay for Primary and Urgent Care Visits • You pay 100% for Specialist and Emergency Room Visits	• You pay a $35 copay for Primary and Urgent Care Visits • You pay 20% / Plan pays 80% for Specialist • You pay 10% or 25% (depending on your plan) for Emergency Room Visits	• Plan pays 100% for Primary and Urgent Care Visits • Plan pays 100% for Specialist and Emergency Room Visits

Preventive Services:

Routine Wellness visits are covered by the plan 100%.

Prescription Costs:

You pay the copay which depends on the drug type and the plan pays the remaining cost.

Out-of-network medical expenses:

When you use out-of-network providers the percent you pay of the allowed amount for covered health care services will usually cost you more than if you had used an in-network provider.

2019 Monthly Rates include:

Medical, Prescription, Dental and Vision

Grandfathered Under and Over 65 Retiree Rates

Retired Prior to 1/1/2009

Monthly Retiree Cost	Blue Options PPO 03559
Retiree Only	$299
Retiree + Spouse	$474
Retiree + Child(ren)	$423
Retiree + Family	$546

Non-Grandfathered Retiree Rates

Retired After 1/1/2009

Under 65 Retirees

	Years of Service			
Blue Options PPO 03559	100% 1-19 Years	70% 20-24 Years	60% 25-30 Years	50% 30+ Years
Retiree Only	$ 606	$ 606	$ 606	$ 585
Retiree + Spouse	$1,366	$1,366	$1,366	$1,171
Retiree + Child(ren)	$1,095	$1,095	$1,095	$1,043
Retiree + Family	$1,783	$1,783	$1,613	$1,345

Blue Options HDHP 05360	100% 1-19 Years	70% 20-24 Years	60% 25-30 Years	50% 30+ Years
Retiree Only	$ 530	$ 503	$ 431	$ 359
Retiree + Spouse	$1,178	$ 825	$ 707	$ 588
Retiree + Child(ren)	$ 956	$ 735	$ 630	$ 524
Retiree + Family	$1,352	$ 946	$ 811	$ 676

Over 65 Retirees

	Years of Service			
Blue Options PPO 03559	100% 1-19 Years	70% 20-24 Years	60% 25-30 Years	50% 30+ Years
Retiree Only	$ 606	$ 606	$ 574	$ 478
Retiree + Spouse	$1,366	$1,341	$1,149	$ 958
Retiree + Child(ren)	$1,095	$1,095	$1,024	$ 853
Retiree + Family	$1,783	$1,539	$1,319	$1,099

Blue Options HDHP 05360	100% 1-19 Years	70% 20-24 Years	60% 25-30 Years	50% 30+ Years
Retiree Only	$ 530	$ 409	$ 350	$ 292
Retiree + Spouse	$ 958	$ 670	$ 575	$ 479
Retiree + Child(ren)	$ 853	$ 598	$ 512	$ 426
Retiree + Family	$1,099	$ 769	$ 659	$ 549

Spousal Surcharge:

Spouses of St. Johns County retirees who work and are eligible for employer-sponsored medical insurance through their employer will be required to pay $100 monthly toward the cost of medical in addition to the rates listed above.

Medical Plan Comparison

Calendar Year Plan Benefits	Blue Options PPO In-Network	Blue Options PPO Out-of-Network	Blue Options HDHP In-Network	Blue Options HDHP Out-of-Network
Calendar Year Deductible (CYD) Per Individual/Family Aggregate	$500/$1,500	$500/$1,500	$1,500/$3,000	$3,000/$6,000
Total Out-of-Pocket Maximum (Includes CYD, coinsurance, medical and prescription copays) Per Individual/Family Aggregate	$3,000/$9,000	$3,000/$9,000	$4,500/$9,000	$9,000/$18,000
Coinsurance (Member Pays)	20%	40%	20%	40%
Adult and Child Wellness Services (Preventive Care)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Mammograms / Routine Colonoscopy (Preventive Care)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Office Visits Primary Care Physician (PCP) Specialist	$ 35 copay 20% after CYD	40% after CYD 40% after CYD	$35 copay 20% after CYD	40% after CYD 40% after CYD
Convenient Care Centers	$ 35 copay	40% after CYD	$35 copay	40% after CYD
Urgent Care Visits	$ 35 copay	$ 35 copay	$35 copay	$35 copay
Emergency Room (facility charge)	10% after CYD	10% after CYD	20% after CYD	20% after CYD
Ambulance Services	20% after CYD	20% after CYD	20% after CYD	20% after CYD
Inpatient Hospital (facility charge) Level 1/Level 2	$600 copay/ $900 copay	40% after CYD	20% after CYD/ 25% after CYD	$500 PAD + 40% after CYD
Outpatient Hospital (facility charge) Level 1/Level 2	$ 150 copay/ $ 250 copay	40% after CYD	20% after CYD/ 25% after CYD	40% after CYD
Ambulatory Surgical Center (facility charge)	$ 100 copay	40% after CYD	20% after CYD	40% after CYD
Provider Services at Hospital and ER	20% after CYD	20% after CYD	20% after CYD	20% after CYD
Provider Services at Ambulatory Surgical Center	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Radiologists, Anesthesiologists, and Pathologists at Ambulatory Surgical Center	20% after CYD	20% after CYD	20% after CYD	20% after CYD
Outpatient Diagnostic Services Labs/Blood Work (Quest Diagnostics only) X-Rays and Advanced Imaging Services (MRI, CT, PET, etc.)	$ 0 $ 100 copay	40% after CYD 40% after CYD	0% after CYD 20% after CYD	40% after CYD 40% after CYD
Durable Medical Equipment, Prosthetics, and Orthotics (DME)	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Benefit Maximums Per Calendar Year				
Autism Spectrum Disorder Services ($200,000 lifetime maximum)	$36,000		$36,000	
Home Health Care Visits	20		20	
Inpatient Rehabilitation Days	30		30	
Mental Health Services - Inpatient Days / Outpatient Visits	20 / 30		20 / 30	
Outpatient Therapies and Spinal Manipulations Visits (combined)	35		35	
Skilled Nursing Facility Days	60		60	
Substance Dependency Care and Treatment (Combined days and/or visits)	10 days/visits		10 days/visits	
Health Reimbursement Account (HRA) Funded by St. Johns County (Annual contribution; prorated for new retirees)	N/A		$600 Retiree Only $1,000 Retiree + Spouse $1,000 Retiree + Children $1,500 - Retiree + Family	

Care Management and Wellness Tools

Florida Blue offers many disease management and care management options for all enrolled plan members. For more information regarding the programs listed below, or to access the Health and Wellness Center, log on to www.floridablue.com.

Care Consultants	• Get assistance in comparing your choices for medical services and prescriptions.	888-476-2227
Care Management Programs	• Programs for diabetes, congestive heart failure, chronic obstructive pulmonary disease, asthma and cardiac conditions.	800-955-5692, Opt. 3 www.floridablue.com
24/7 Nurseline	• Licensed nurses available 24/7 to provide support with significant medical decisions and symptom management.	877-789-2583

DME and Home Health Providers

CareCentrix, Florida Blue's DME supplier, has an established network of providers, accessible throughout Florida, which many Florida Blue providers are already part of.

Services

Durable Medical Equipment (DME) is any medical equipment used in the home to aid in a better quality of living. Examples of DME include a nebulizer, CPAP machine and supplies, wheelchair, a boot, or diabetic supplies.

Home Health Agencies provide professional home health services, such as wound care, medication teaching, pain management, disease education and management, speech therapy, physical therapy or occupational therapy. Home care is often an integral component of the post-hospitalization recovery process, especially during the initial weeks after discharge when the patient still requires some level of regular physical assistance.

How to Find a Participating Provider

To find participating, in-network providers for DME and Home Health Care services, go to www.floridablue.com and click on Find a Doctor.

Under Step 1, choose Support Service and select either Durable/Home Medical Equipment or Home Health Agency.

Under Step 2, select your plan name.

Under Step 3, fill in the criteria for your location.

Click the Search button and see your results.

For more information, or for assistance in finding a provider, please call CareCentrix at (877) 561-9910. Or, call Florida Blue at (800) 352-2583.

St. Johns County Funded-Health Reimbursement Account (HRA)

800-523-7542 • medcom.wealthcareportal.com

MEDCOM
Your employee benefit solution center

An HRA is a great way to pay for covered medical, prescription, dental and vision expenses through the plan year. All retirees who enroll in the Blue Options High Deductible Health Plan (HDHP) 05360 are automatically enrolled in a Health Reimbursement Account (HRA). The HRA is a reimbursement plan funded by St. Johns County, which designated a specific dollar amount to credit to your HRA per calendar year.

	Health Reimbursement Account (HRA)
How it works	For retirees enrolled in the Blue Options (HDHP), the County deposits money into your account to help pay for eligible medical, dental, vision, and prescription drug expenses.
Who is eligible to use Funds	Retirees enrolled in the HDHP and ONLY their dependents enrolled on the health plan
Employer Contribution	Yes $ 600 – Retiree Only $1,000 – Retiree + Spouse $1,000 – Retiree + Children $1,500 – Retiree + Family *Note: The HRA contribution will be pro-rated on a monthly basis for retirees whose benefits become effective after January 1.*
Employee Contribution	None
When is Money Available	The total amount of your account is available January 1, or date of eligibility.
Deadline to Use Funds	December 31
Can Unused Funds Rollover to Next Year	No

Prescription Plan

Mail-Order: 866-284-9226• www.caremark.com

All retirees who enroll in one of the St. Johns County Medical Plans will be automatically enrolled in the Prescription Plan through CVS/Caremark. This plan has four tiers: Generic, Preferred Brand Name and Non-Preferred Brand Name, and Specialty. The tier that your medication is in determines your portion of the drug cost. Prescription coverage is included in your medical plan premium.

Prescription Drug Benefits	Retail (30-day supply)	Retail 90/Mail-Order (90-day supply)
Generic	$ 10 copay	$ 20 copay
Preferred Brand	$ 50 copay	$ 100 copay
Non-Preferred Brand	$ 75 copay	$ 150 copay
Specialty	$500 deductible, then normal copays apply	Not available

Are all prescription drugs covered?

No, a complete list of drugs not covered is available on the CVS/Caremark website.

Do I have to use certain pharmacies?

You can use any pharmacy you choose, but **cost savings are highest** when you use a participating pharmacy in CVS/Caremark's network.

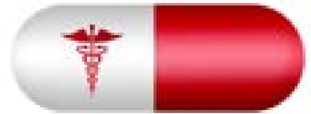
Can I only fill my prescriptions for 30 days at a time?

In addition to using an in-network retail pharmacy to receive a 30-day prescription, you also have the option of getting a 90-day supply for your maintenance medications prescribed by your doctor at a CVS Pharmacy or by mail order through CVS/Caremark.

Prescription Specialty Program

Mail-Order: 800-237-2767• www.cvsspecialty.com

Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical conditions are typically more difficult to maintain, administer and monitor when compared to traditional drugs. Specialty medications treat rare or complex conditions including, but not limited to, Hepatitis C, Multiple Sclerosis, Psoriasis, Oncology and Rheumatoid Arthritis, and often require special handling, storage and administration. Specialty medications must be filled by a specialty pharmacy, a provider of complex medications for complex health conditions. CVS Caremark Specialty Pharmacy is your provider for the St. Johns County Self-Funded Medical Plan.



Getting Started: After your medication is prescribed, you will need to obtain Pre-Authorization from your doctor. It is important to remember that whenever the doctor changes the dose or strength of the medication, it is treated as a new prescription, which will need to go through the entire process as a new specialty medication.

Step 1: Filling your Prescription: You or your doctor must clarify with the Pharmacist that your order is being placed through **Specialty Connect,** which is a separate system the pharmacists access. The Copay method of payment can be made via phone or through CVS Caremark Specialty Pharmacy.

Step 2: Delivery Options: You can choose between in-store pickup at your local CVS pharmacy, or UPS delivery of your medication to your home or doctor's office.

Personalized Care: You will receive dedicated clinical support by phone from a team of specialty pharmacy experts trained in your therapeutic area. Available 24 hours a day, 365 days a year. Call toll free at 1-800-869-0479.

Convenient Online Prescription Management: Register for a secure, online specialty prescription profile and make managing your medication even easier with these online tools at www.cvsspecialty.com.

Dental Plan

800-233-4013 • www.humana.com

Dental health is the gateway to your overall well-being and is one of the most sought after health benefits. Dental disease is largely preventable through effective preventive care to keep your teeth and gums healthy, as well as help reduce future costly procedures. All retirees who enroll in one of the St. Johns County Medical Plans will be automatically enrolled in the Dental Plan through Humana Dental.

Do I have to use certain dental providers?

You can see any dentist you choose, but **cost savings are highest** when you use a provider in Humana's network. You can find in-network providers by calling Humana or visiting their website.

Is there a maximum age for orthodontia coverage?

Orthodontia coverage is available to any covered plan participant, regardless of their age. There is no waiting period for othodontia services.

Calendar Year Plan Benefits	Examples of Service	In- and Out-of-Network
Calendar Year Deductible (CYD) Per Individual Family Aggregate	Applies to basic and major services	 $50 $100
Preventive Services (Plan covers)	Routine exams, cleanings, bitewing x-rays; fluoride treatment and space maintainers for children	100%
Basic Services (Plan covers)	Fillings, extractions, endodontics, peri-odontics, oral surgery, and general anesthesia	80%
Major Services (Plan covers)	Crowns, dentures, bridges, and implants	50%
Regular Benefit Maximum (RBM) Per Individual	RBM covers the cost of preventive, basic, and major services	$1,000
Wisdom Teeth Extraction Maximum Per Individual	Wisdom teeth extractions	$1,000
Orthodontic Benefit Per Individual (*$1,000 lifetime maximum*)	Exams, x-rays, extraction and applicances for orthodontic services	100%

Note: If you choose to receive your dental care from an out-of-network dentist, you may be balance billed the difference between their charge and what your Humana dental plan allows. For example, let's say an out-of-network dentist charges $100 but your plan will only allow for $70. The dentist may bill you for the remaining $30 in addition to what you may owe for your deductible or coinsurance.

Humana

Vision Plan

877-398-2980 • www.humana.com

Vision exams can identify the signs of many serious health conditions and annual check-ups are critical to your overall health. All employees who enroll in one of the St. Johns County Medical Plans will be automatically enrolled in the Vision Refresh Plan through Humana, utilizing the Humana Insight Network. The Vision Refresh Plan provides comprehensive routine vision coverage and does not include medical or surgical treatment of the eyes.

Do I have to use certain vision providers?

You can see any vision provider you choose, but **cost savings are highest** when you use a participating provider in Humana's network.

What is a Benefit Allowance?

A benefit allowance gives you a certain dollar amount toward contacts and glasses (lenses and frames). As long as you choose materials that are within that dollar amount, or allowance, they are covered at 100%. If you choose a frame exceeding your plan allowance, you'll be responsible for paying the overage in addition to any applicable copays at the time of your visit.

Can I get contacts and glasses in the same calendar year?

You can only get contacts OR glasses in the same calendar year, not both.

Do I have to file a claim to use this benefit?

If you stay in-network, your provider will file the claim. If you go out-of-network, you will need to download a Humana Vision Claim Form to be reimbursed.

Frequency (based on calendar year)	
Routine Vision Exam	Once per year
Lenses or Contact Lenses	Once per year
Eye Glass Frames	Once every other year

Benefit	In-Network	Out-of-Network
Routine Eye Exam	$10 Copay	Up to $30
Prescription Lenses		
Single Lenses	$15 Copay	Up to $25
Lined Bifocal Lenses	$15 Copay	Up to $40
Lined Trifocal Lenses	$15 Copay	Up to $60
Lenticular Lenses	$15 Copay	Up to $100
Eye Glass Frames		
Frames	Allowance	Reimbursement
Max Benefit/Allowance	$130 Retail	$65 Retail
Discount over Allowance	20%	N/A
Contact Lenses		
Standard Fit and Follow-up	Up to $40[1]	Not Covered
Conventional/Disposable Contacts	$130 Allowance	Up to $104
Medically Necessary Contacts	Paid in Full	Up to $200
Diabetic Eye Care		
Exam	$0	Up to $77
Retinal imaging	$0	Up to $50
Scanning laser	$0	Up to $33
Laser Correction Discount	15% off retail prices	N/A
Provider Network (Humana Insight)	Optometrist and Retail	N/A

Stay in network to avoid extra costs

Choosing doctors, hospitals, and other providers outside of the participating network can cost you more money. Using providers in the Florida Blue network (medical), CVS/Caremark (pharmacy) and the Humana network (dental and vision), whenever possible, can help you lower your healthcare costs. When you use an out-of-network provider, they may charge you more and they could bill you (where permitted) for the difference your plan doesn't cover. That's called balance billing.

What is an out-of-network provider?

An out-of-network provider is a doctor, care professional (nurse practitioner, anesthesiologist, etc.) or facility (hospital, lab processing facility, ambulatory surgery center, etc.) that isn't part of your plan's network. The insurance companies negotiate with providers and facilities to provide services at lower rates, and that's how doctors and hospitals become part of the network. Out-of-network providers do not have contracts with the insurance companies.

What happens when I use an out-of-network hospital or provider?

Your out-of-pocket costs (like copayments, coinsurance, and deductibles) will be higher. That's because you're charged the full price for a service, and not the lower, negotiated rate you'd pay through the network.

How often do I need to check to make sure my provider is in the network?

Providers can come in or drop out of networks at any time. It is good practice to verify every time before you go to a facility or doctor.

What is an allowable charge?

An allowable charge is the amount the insurance company allows for a covered healthcare service. The amount Florida Blue allows an out-of-network provider to charge Florida Blue for a covered service is called the allowed amount. The amount Humana allows an out-of-network provider to charge Humana for a covered service is called a maximum allowable fee (MAF).*

What is balance billing?

Balance billing is when an out-of-network provider bills you for the difference between their charge and what your health plan will allow. For example, let's say an out-of-network doctor charges $100 to review your MRI, but your plan will only allow for $70. The doctor may bill you for the remaining $30 in addition to what you may owe for your deductible or coinsurance.

*Note: Any balance bill you may pay will not apply to your deductible or maximum out-of-pocket limit for the plan year. *Also referred to as "usual and customary" amount.*

How To Find a Provider

Florida Blue, CVS/Caremark and Humana offer quick and easy tools to help you find an in-network doctor, specialist or pharmacy in your area. Never rely on your medical or dental provider to tell you whether you are in or out-of-network. You can call the Customer Service or go online and look up providers.

Medical-Florida Blue
Customer Service:
800-352-2583 or
www.floridablue.com

Prescription-CVS Caremark
Customer Service:
844-278-5590
www.caremark.com

Dental- Humana
Customer Service:
800-233-4013 or
www.humana.com

Vision- Humana
Customer Service:
877-398-2980 or
www.humana.com

Blue Card Program

800-810-2583 • www.provider.bcbs.com

When you're a Blue Cross and Blue Shield 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.

Basic Life Insurance

St. Johns County provides all retirees, who are enrolled as a retiree on one of the St. Johns County Medical Plans, with Basic Life Insurance. Basic Life coverage is provided through The Standard.

Do I need to name a beneficiary?

Yes. It is important to designate the person that you want to receive your life insurance money. You can name or change your beneficiaries at any time by contacting your Benefits department.

Does this benefit include spouse life insurance?

No, this benefit does not include life insurance for spouses.

Basic Life Insurance Amount for Retirees
$5,000

Emergency Travel Assistance

800-527-0218 • www.standard.com/travel • Policy # 9061

All retirees and their spouses have FREE access to UnitedHealthcare (UHC) Global emergency travel assistance through The Standard. UHC Global responds quickly and efficiently when members experience travel health emergencies more than 100 miles (150 km) from home or internationally for up to 180 days for business or pleasure. Some of the benefits available are:

- Medical Consultation and Evaluation
- Lost Luggage or Document Assistance
- Emergency Message Transmission
- Emergency Medical Evacuation
- Care of Minor Children
- Prescription Assistance
- Pre-Trip Information
- Emergency Cash Coordination
- Legal and Interpreter Referrals

Life Services Toolkit

800-378-5742 • www.standard.com/mytoolkit • User Name: assurance

The Standard has partnered with Morneau Shepell to offer online tools and services, which can help you create a will, make advance funeral plans, and put your finances in order.

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

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

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

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

Beneficiary Services: Life insurance beneficiaries can access services for 12 months after the date of death, or 12 months after the date of payment for recipients of an Accelerated Benefit. Supportive services can help your beneficiary cope after a loss, including **grief support** (up to six face-to-face sessions with a professional counselor and unlimited phone support), **legal services** (schedule an initial 30-minute office and a telephone consultation with a network attorney, and receive a 25% rate reduction for retaining the same attorney), **financial assistance** (unlimited phone access to financial counselors for your beneficiaries), and more.

Covering Spouses or Other Dependents

If you are eligible for medical coverage, you can also enroll your spouse and/or eligible dependent children for medical, prescription, dental, and vision coverage. You must provide documentation proving that your dependents meet eligibility requirements.

Eligible dependents	Required documentation
Spouse: The Retiree's spouse under a legally valid existing marriage.	Marriage Certificate **AND** current document establishing current relationship status (i.e. tax return, joint bill, insurance policy). Document MUST be dated within the last six (6) months.
Child(ren): The Retiree's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Retiree has been court-appointed as legal guardian or legal custodian). Can be covered on the plan up to the end of the month in which they turn 26, or in the case of a foster child, is no longer eligible under the Foster Child Program.	Birth Certificate naming the retiree as the child's parent OR appropriate court order/adoption decree naming the retiree or retiree's spouse as the child's legal guardian.
Stepchild(ren): The biological offspring or adopted child of a retiree's eligible spouse. Can be covered on the plan up to the end of the month in which they turn 26.	Birth Certificate naming spouse as the child's parent **AND** above documentation required for a spouse.
Grandchild(ren): The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.	Birth Certificate naming retiree's dependent child as the parent
Handicapped Children: Children of any age who become totally and permanently disabled before age 26.	Proof of the disability will be a statement from the dependent's physician certifying that the dependent was incapacitated or disabled prior to the limiting age, is incapable of self sustaining employment by reason of mental or physical disability, and is fully dependent upon the contract holder for support.

You must submit required documentation for your eligible dependents within 30 days of enrolling. If documentation is not provided, coverage for the dependent(s) will be denied.

NOTICE: As prohibited by the rules of the program, the following acts will be treated as fraud or misrepresentation of material fact:

- falsifying dependent information or documentation
- certifying ineligible persons as eligible
- enrolling ineligible persons in coverage
- falsifying the occurrence of life events or life event documentation
- failing to remove dependents from coverage within 30 days of when they lose eligibility

Such acts will require you to reimburse the plan for any claims incurred.
Legal and disciplinary action may be taken.

Premium Assistance Under Medicaid and Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). Florida: Website: http://flmedicaidtplrecovery.com/hipp/. Phone: 1-877-357-3268.

Women's Health & Cancer Rights Act of 1998 (WHCRA) Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed, prostheses, treatment of physical complications of the mastectomy, including lymphedema, and surgery and reconstruction of the other breast to produce a symmetrical appearance. 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 the Plan Administrator (contact information provided at the end of this communication).

Credible Coverage & Medicare Notice
This notice has information about your current prescription drug coverage with your employer group plan 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. The Plan Administrator has determined that the prescription drug coverage offered by your employer's group medical plan is, on average for all participants, expected to pay out as much as the 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.

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. If you decide to join a Medicare drug plan and drop your current coverage under the employer group 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/). You should also know that if you drop or lose your current coverage with your employer 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.
For More Information About This Notice or Your Current Prescription Drug Coverage Contact your HR Department.
For More Information About Your Options Under Medicare Prescription Drug Coverage… Visit www.medicare.gov or 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.
NOTE: You will also get this notice before the next period you can join a Medicare drug plan, and if your current coverage changes. You also may request a copy of this notice at any time. **Remember**: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). 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 1-800-772-1213 (TTY 1-800-325-0778).

Date:	10/1/2018
Name of Entity:	St. Johns County

CMS Form 10182-CC

Notice to Employees in a Self-Funded Non-federal Governmental Group Health Plan

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below 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:

Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the 2019 plan year beginning January 1, 2019 and ending December 31, 2019. The election may be renewed for subsequent plan years.

St. Johns County Notice of Privacy Practices

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

(Continued on next page)

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
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.

(Continued on next page)

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 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
Your Benefits Representative (see page 24)
Privacy Officer
St. Johns County
St. Augustine, FL 32084

Medical	800-352-2583	ID Card
Florida Blue Blue Options Network Group #13902	www.floridablue.com *Member Login > Tools > Find a Doctor and More*	Yes
BlueCard Program *National and Worldwide Coverage*	800-810-BLUE (2583) http://provider.bcbs.com	No *(same as medical ID)*
Care Consultants *Know Before You Go*	888-476-2227 www.floridablue.com *Member Login > Tools > Compare Medical Costs or Compare Drug Prices*	
CareCentrix *Durable Medical Equipment (DME)*	877-561-9910	
Prescription	**844-278-5590**	
CVS Caremark CVS National Pharmacy Network Group #RX2787 Bin #004336, PCN - ADV	Mail-Order: 866-284-9226 Caremark Specialty: 800-237-2767 www.caremark.com	Yes
Specialty Pharmacy Retail 90 CVS Pharmacy	www.cvsspecialty.com	
Dental	**800-233-4013**	
Humana PPO Network Group #677885	www.humana.com *Top Menu > Find a Dentist*	Yes
Vision	**877-398-2980**	
Humana Humana Insight Network Group #014572	www.humana.com *Top Menu > Find a Doctor > Select "Vision"*	Yes
HRA	**800-523-7542, Option 1**	
Medcom	https://medcom.wealthcareportal.com	Yes
Life and AD&D	**888-937-4783**	
The Standard Group # 164622	www.standard.com	No
Value-Added Services (at no additional cost)	Travel Assistance: 800-527-0218, Policy #: 9061 Life Services Toolkit: 800-378-5742	
Human Resources		
Board of County Commissioners Tax Collector Clerk of Courts Supervisor of Elections Property Appraiser Sheriff's Office	904-209-0635 (Benefits option 5) bccbenefits@sjcfl.us 904-209-2286 904-819-3605 904-823-2238 904-827-5522 904-209-1518 SOriskmanagement@sjso.org	
Benefit Administration	**904-461-1800**	
The Bailey Group	Rachael Friedman: rfriedman@mbaileygroup.com Debbie Weiner: dweiner@mbaileygroup.com	