# Supplement to the Blue Options Benefit Booklet for Covered Plan Participants of Monroe County BOCC Group Health Plan

**Effective as of January 1, 2017**

This is a supplement to the Blue Options Benefit Booklet ("Booklet") and is intended to provide information not otherwise included in the Booklet. In the event of a conflict between this Supplement and the Booklet, the provisions of this Supplement shall govern. In the event of a conflict between this Supplement and a County Resolution, the County Resolution shall govern.

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**RESOLUTION NO. 081-1998 – DOMESTIC PARTNERSHIP**

**Eligible Domestic Partner** means an individual who meets the requirements of Resolution No. 081-1998 as restated below:

14.02 DEFINITIONS

A. Domestic Partners. "Domestic Partners" are two adults who have chosen to share one another's lives in a committed family relationship of mutual caring. Two individuals are considered to be Domestic Partners if:
1. they consider themselves to be members of each others immediate family;
2. they agree to be jointly responsible for each other's basic living expenses;
3. neither of them is married or a member of another Domestic Partnership;
4. they are not blood related in a way that would prevent them from being married to each other under the laws of Florida;
5. each is at least of the legal age and competency required by Florida law to enter into a marriage or other binding contract;
6. they must each sign a Declaration of Domestic Partnership as provided for in Section 14.03 of Monroe County BOCC's Personnel Policies and Procedures Manual;
7. they both reside at the same address.

B. Joint Responsibility for Basic Living Expenses. "Basic living expenses" means basic food and shelter. "Joint responsibility" means that each partner agrees to provide for the other's basic living expenses while the domestic partnership is in effect if the partner is unable to provide for him or herself. It does not mean that the partners must contribute equally or jointly to basic living expenses.

C. Competent to Contract. "Competent to Contract" means the two partners are mentally competent to contract.

D. Domestic Partnership. "Domestic Partnership" means the entity formed by two individuals who have met the criteria listed above and file a Declaration of Domestic Partnership as described below.

E. Declaration of Domestic Partnership. "Declaration of Domestic Partnership" or "DDP" is a form provided by the Human Resources Director. By signing it, two people swear under penalty of perjury that they meet the requirements of the definition of domestic partnership when they sign the statement. The form shall require each partner to provide a mailing address.

F. Dependent. "Dependent" means an individual who lives within the household of a domestic partnership and is:
1. A biological child or adopted child of a domestic partner; or
2. A dependent as defined under County employee benefit plan document.
3. A ward of a domestic partner as determined in a guardianship proceeding.

G. Employee means an employee of the Board of County Commissioners, the constitutional officers or the Mosquito Control Board, except where the context is otherwise.

## 14.03 ESTABLISHING A DOMESTIC PARTNERSHIP

A. An employee and his/her domestic partner as set out in Section 14.02 are eligible to declare a Declaration of Domestic Partnership (hereafter DPP) in the presence of the Human Resources Director, or the employee partner may present a signed and notarized DDP to the Human Resources Director. The DDP shall include the name and date of birth of each of the domestic partners, the address of their common household, and the names and dates of birth of any dependents of the domestic partnership, and shall be signed, under the pain and penalties of perjury, by both domestic partners and witnessed (two) and notarized.

B. As further evidence of two individuals being involved in a domestic partnership, two of the following documents must be presented along with the DDP to the Human Resources Director:

1. A lease, deed or mortgage indicating that both parties are joint responsible;
2. Driver's licenses for both partners showing same address;
3. Passports for both partners showing the same address;
4. Verification of a joint bank account (savings or checking)
5. Credit cards with the same account numbers in both names;
6. Joint wills;
7. Powers of attorney; or
8. Joint title indicating both partners own a vehicle.

C. An individual cannot become a member of a domestic partnership until at least six months after any other domestic partnership of which she or he was a member has ended and a notice that the partnership has ended was given as provided for in Section 14.04. This does not apply if their domestic partners are deceased.

D. Domestic partners may amend the DDP to add or delete dependents or change the household address. Amendments to the DDP shall be executed in the same manner as the declaration of a domestic partnership.

## 14.04 TERMINATION OF A DOMESTIC PARTNERSHIP

A. A domestic partnership is terminated when:

1. one of the partners dies;
2. one of the partners marries; or
3. a domestic partner files a termination statement with the Human Resources Director. A domestic partnership may be terminated by a domestic partner who files with the Human Resources Director by hand or by certified mail, a termination statement. The person filing the termination statement must declare under pain and penalties of perjury that the domestic partnership is terminated and that a copy of the termination statement has been mailed by certified mail to the other domestic partner at his or her last known address. The person filing the termination statement must include on such statement the address to which the copy was mailed.

B. The termination of a domestic partnership shall be effective immediately upon the date of a domestic partner. The voluntary termination of a domestic partnership by a partner shall be effective thirty (30) days after the receipt of a termination

statement by the Human Resources Director. If the termination statement is withdrawn before the effective date, the domestic partner shall give notice of the withdrawal, by certified mail, to the other domestic partner.

C. If a domestic partnership is terminated by the death of a domestic partner, there shall be no required waiting period prior to filing another domestic partnership. If a domestic partnership is terminated by one or both domestic partners, neither domestic partner may file another domestic partnership until six (6) months have elapsed from effective termination.

D. It is the obligation of the employee domestic partner to notify the Human Resources Director of the termination of a domestic partnership as soon as possible after it occurs.

14.05 HUMAN RESOURCES DIRECTOR RECORDS

A. The Human Resources Director will keep a record of all employees DDP's, Amendments and Termination Statements. The records will be maintained so that DDPs, Amendments and Termination Statements will be filed to which they apply.

B. The Human Resources Director shall indentify on the DDP what type of documents was presented for further verification of the domestic partnership.

C. Upon determination by the Human Resources Director that the DDP is complete and that further evidence of the domestic partnership has been presented as provided in Section 14.03(B); the Human Resources Director shall provide the employee with a copy of the DDP. The employee/domestic partner shall become eligible to elect domestic partnership health and other employee fringe benefits as provided in Section 14.06. It will be the employee's responsibility to notify the Employee Benefits Section of their intent to enroll the domestic partner and/or any eligible dependents under the Monroe County Employee Benefit Plan. Domestic partner/dependents enrolled in the Monroe County Employee Benefit Plan are subject to the same rules and provision applicable to covered spouses/dependents.

D. The Human Resources Director shall provide forms to employees requesting them.

E. The Human Resources Director shall allow public access to domestic partnership records to the same extend and in the same manner as any other public record.

**RESOLUTION NO. 388-2013 – RETIREMENT ELIGIBILITY FOR GROUP HEALTH PLAN**

**Eligible Retiree** means an individual who meets one of the following requirements as established by the Board of County Commissioners Resolution No. 388-2013 – Retirement Eligibility Requirements for Group Health Insurance Coverage for Monroe County Employees:

- Hire date prior to 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire under the FRS on, or after, the Normal Retirement date as described in Section 121.021(29), F.S.; and covered under the Plan at retirement. Current contribution is $5.00 per month for each year of creditable service with the Florida Retirement System at the time of retirement with Monroe County. Premium minimum is $50 for ten years of service and the premium maximum is $150 for 30 years of service.
- Hire date prior to 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire under the FRS at an Early Retirement date as described in Section 121.021(30), F.S.; covered under the Plan at retirement; 60 years of age or age and years of service must satisfy Rule of 70** at time of retirement.
  Current contribution is $5.00 per month for each year of creditable service with the Florida Retirement System at the time of retirement with Monroe County. Premium minimum is $50 for ten years of service and the premium maximum is $150 for 30 years of service.
- Hire date prior to 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire under the FRS at an Early Retirement date as described in Section 121.021(30), F.S.; covered under the Plan upon retirement; NOT 60 years of age and age and years of service do not satisfy Rule of 70**. Current contribution is the departmental rate.
  Upon attaining either the age of 60 or satisfy Rule of 70** the contribution will change to the current contribution of $5.00 per month for each year of creditable service with the Florida Retirement System at the time of retirement with Monroe County. Premium minimum is $50 for ten years of service and the premium maximum is $150 for 30 years of service.
- Hire date on or after 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire with the FRS as described in Section 121.021(29 or 121.021 (30), F.S.; covered under the Plan upon retirement. Current contribution is departmental rate.
- Retire from FRS as described in Section 121.021(29) or 121.021(30), F.S.; less than ten (10) years of full-time service with Monroe County; covered under the Plan upon retirement. Current contribution is the departmental rate.
- Former Eligible Employee with at least ten (10) years of full-time service with Monroe County; covered under the Plan upon termination of employment and fully vested under FRS who elect not to retire under FRS upon termination of employment with Monroe County, may elect to re-enroll under the Plan upon retirement under FRS, provided that Monroe County was their last FRS employer. Current contribution is the departmental rate.

*HIS: Health Insurance Subsidy per Section 112.363, Florida Statutes.
**Rule of 70: Eligible Retirees satisfy the Rule of 70 if their age, combined with the number of years of service with Monroe County, totals 70 or more.

## RE-ENROLL ELIGIBILITY FOR FORMER EMPLOYEES RETIRING WITH FRS

### Former Employee Retiring with FRS -

An individual who meets the eligibility criteria specified below is an Eligible Retiree and is eligible to apply for coverage under the Blue Options Benefit Booklet for Covered Monroe County Group Health Participants:

> A person who elects to continue re-enroll in the Monroe County Group Health Plan at the time of their official retirement under the Florida Retirement System (FRS), and is not currently an Eligible Employee but Monroe County was their last FRS employer prior to retirement. Coverage will be offered within 30 days of retirement.
>
> **If the Eligible Retiree fails to elect retiree coverage at time of retirement, waives retiree coverage or lets coverage lapse, the Eligible Retiree will permanently lose entitlement to re-enroll under the Monroe County Group Health Plan.**

## MEDICARE COORDINATION OF BENEFITS AFTER RETIREMENT

Retirees, their eligible dependents, or a surviving spouse who becomes eligible for Medicare due to age 65, End state Renal Disease (ERSD), or disability **must notify the Monroe County BOCC Benefits Office immediately.** It is the responsibility of the ensured to enroll in Medicare as soon as they are eligible. Medicare will become the Primary Payer and coverage under the Monroe County Health Plan will become the Secondary Payer.

The Monroe County BOCC will not be liable to any individual covered under this health plan on account of any nonpayment of primary benefits resulting from failure to be timely notified by the enrolled participant of their eligibility for enrollment in Medicare.

## OPT OUT

*Initial Enrollment Period* means the 30 day period starting on your date of hire during which you and your eligible dependent(s) have the ability to either elect coverage for yourself and/or your eligible dependents, or Opt Out of coverage. You can Opt Out by indicating that you elect to waive coverage on the Monroe County Benefits Enrollment Form. If you Opt Out during your Initial Enrollment Period, you will not be able to enroll in the Monroe County Group Health Plan unless you have a Special Enrollment right or during a future Open Enrollment Period.

*Open Enrollment Period* means the period selected by Monroe County during which you can elect coverage for yourself and/or your eligible dependents, or Opt Out of coverage, for the immediately following Plan Year. You can Opt Out by indicating that you elect to waive coverage on the Monroe County Benefits Enrollment Form. If you Opt Out during the Open Enrollment Period, you will not be able to enroll in the Monroe County Group Health Plan unless you have a Special Enrollment right or during a future Open Enrollment Period.

**CESSATION OF ACTIVE WORK - Insurance Coverage While on Leave of Absence**

The Plan will continue to maintain group insurance benefits for employees while on approved paid leave status.

*MEDICAL LEAVE* - If an Eligible Employee ceases Active Work due to illness, injury or pregnancy the Employer in its sole discretion may approve a medical leave of absence. Coverage for the Eligible Employee will continue under the Plan, but for no longer than six (6) months from the date the approved medical leave begins, including any approved FMLA leave. Coverage of Eligible Dependents will continue during this time provided required premiums are continued to be paid. Notification of all approved medical leave must be provided to the Monroe County Group Health Plan Administrator (Benefits Office) by the Employer. The notification should contain the date on which the leave began and when it will end. **An Eligible Employee who has been on an approved medical leave must return to active work for a minimum of 30 days after the approved medical leave ends. In the event an Eligible Employee on an approved medical leave does not return to active work at the end of the leave, the Eligible Employee will be required to reimburse the Plan for the health benefit premiums paid during the leave to continue coverage.**

***EXCEPTION:** When an Eligible Employee fails to return to active work because of the continuation, recurrence, or onset of either a serious health condition of the Eligible Employee or an Eligible Employee's family member the Plan will not recover the health benefit premium payments made on the Eligible Employee's behalf during the approved medical leave. The Monroe County Group Health Plan Administrator (Benefits Office) may require medical certification of the Eligible Employee's or the Eligible Employee's family member's serious health condition.

If leave extends beyond the maximum allowed period of six months and the employee is on a non-paid status, said employee must make the monthly premium payments for themselves in order to continue health insurance coverage. Failure to make payment(s) on a timely basis will result in termination of coverage.

*PERSONAL LEAVE* – If personal leave without pay is approved by the Employer, said employee must reimburse the Plan for the health benefit premiums paid during the leave to continue coverage. Coverage of Eligible Dependents will continue during this time provided required premiums are continued to be paid. Personal Leave under the Plan cannot exceed six (6) months.

## Rehire/Reinstatement

If subsequent to termination of coverage an Eligible Employee is rehired or reinstated as an Eligible Employee the Eligible Employee must meet the eligibility requirements in the Eligibility for Coverage section. However, the Plan allows a grace period of 2 days following the date of termination of coverage during which an Eligible Employee may be rehired or reinstated without penalty.

## Active Military Duty

Return from active military duty by a former Eligible Employee of two weeks or longer who is rehired or reinstated will be treated as if the Eligible Employee were on an approved leave of absence for purposes of eligibility under the Plan. The Plan's waiting period or preexisting condition exclusion period will not be applicable

### CONTINUATION OF COVERAGE

**Eligible Retirees**: If any Eligible Retiree fails to elect retiree coverage at time of retirement, waives retiree coverage or lets coverage lapse, the Eligible Retiree will permanently lose entitlement to re-enroll under the Monroe County Group Health Plan.

**Surviving Spouses of Covered Retirees:** Upon the death of a Covered Retiree, the Surviving Spouse may continue coverage under the Monroe County Group Health Plan provided: (1) the Surviving Spouse does not remarry; and (2) the Surving Spouse makes timely payment of any required contribution. It is the sole responsibility of the Surviving Spouse to notify the Monroe County Group Health Plan Administrator (Employee Benefits Office) of a change in marital status.

**Domestic Partners:** For purposes of COBRA Continuation Coverage Rights, a Domestic Partner of an Eligible Employee shall be treated as the Eligible Employee's "spouse" and the dependent child(ren) of a Domestic Partner shall be treated as the Eligible Employee's stepchild(ren).

# GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

## Introduction

You're getting this notice because you recently gained coverage under a group health plan (Monroe County Group Health Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

### What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

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

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

## When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to:** ***Maria Fernandez-Gonzalez, Benefits Administrator, 1100 Simonton Street, Suite 2-268, Key West, FL 33040; Facsimile (305) 292-4452.***

## How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

### *Disability extension of 18-month period of COBRA continuation coverage*

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months.

***NOTE**: The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. **A copy of the letter from Social Security with the date disability was determined and approved must be provided this to:** ***Maria Fernandez-Gonzalez, Benefits Administrator, 1100 Simonton Street, Suite 2-268, Key West, FL 33040; Facsimile (305) 292-4452.***

### *Second qualifying event extension of 18-month period of continuation coverage*

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

## Are there other coverage options besides COBRA Continuation Coverage?

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

## If you have questions

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

## Keep your Plan informed of address changes

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

## Plan contact information

You can obtain information about the Monroe County Group Health Plan and COBRA from:

Natalie Maddox, Coordinator
1100 Simonton Street, Suite 2-268
Key West, FL 33040
Phone: 305-292-4450
Email: maddox-natalie@monroecounty-fl.gov

## SELF-FUNDED PROGRAMS

Where the Board of County Commissioners has determined that the use of a self-funded program is in its best interest, it will be the County Administrator's responsibility to oversee the Administration of said programs. Any proposed change to the self-funded health insurance program that would constitute a material reduction in benefits or change in cost to current employees and retirees that will be presented to the Board of County Commissioners will be preceded by a two week written notice to the affected employees and retirees.

## NON-TOBACCO USE POLICY

Monroe County BOCC has implemented a non-tobacco use policy for all newly enrolled Medical Health plan members effective January 1, 2015.

All Newly Enrolled individuals in the Medical Health Plan will be assessed a surcharge if currently using tobacco products.

Tobacco products are defined as cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, electronic or e-cigarettes that contain nicotine or any other product that contains tobacco or nicotine. Nicotine replacement products, such as gum and patches, are also considered tobacco products.

### Tobacco user Surcharge & Penalty

1. The non-tobacco use policy applies to employees and their dependents enrolled in the medical health and prescription benefit plans. Enrolled employees are required to complete the Tobacco Use Attestation Certification form within 30 days of enrollment. Failure to complete and return the Tobacco Attestation Certification form will be treated as an admission that the employee is a tobacco user.

2. Each newly covered dependent(s) over the age of 18 must complete the Tobacco Use Attestation form before dependent coverage becomes effective.

3. Changes in the use of tobacco products by anyone covered in the plan require the immediate completion of a new certification form.

4. Discontinuing the use of tobacco products requires a new non-tobacco user certification.

5. Using tobacco products requires a new tobacco user certification.

6. All certification forms must be submitted to the BOCC Group Benefits office.

7. Tobacco users will be charged a monthly surcharge of $50 each per month.

8. Failing to certify or providing false information will result in a $50 surcharge and a penalty of $50 each per month (Total $100 each per month).

9. Nonrefundable surcharges and/or penalties for the employee and/or dependents will be deducted from the employee's next paycheck in accordance with the payroll schedule.

10. Changes to the surcharge and penalties will be processed by the group benefits office in accordance with the employer's next payroll schedule.

11. In the absence of a completed Non-Tobacco use Attestation Certification Form, the surcharge will be assessed.

12. Please obtain the Tobacco use Attestation Certification form from the group benefits office.

The BOCC Group Health Plan is committed to helping you achieve your best health. The ability to avoid the Tobacco Use Surcharge is available to all employees. If you think you might be unable to meet a standard to avoid the Tobacco Use Surcharge, you might qualify to avoid the surcharge by different means. Contact the group benefits office and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

# Important Notice about False or Fraudulent Insurance Claims

As the sponsor of a medical insurance plan, Monroe County is an "insurer" when it comes to the medical insurance plan offered to you and other eligible employees. You should understand that insurance fraud is a punishable crime under Florida law. Fraud occurs when you or a provider intend to injure, defraud or deceive an insurer. Fraudulent acts can include such things as:

- Presenting any written or oral statement as part of or in support of a claim for payment, knowing that such statement contains any false, incomplete or misleading information.
- Knowingly concealing information concerning any fact material to an application for insurance.
- Agreeing with a service provider other than a hospital to waive deductibles or copayments when the service provider will bill the County's medical plan for its usual and customary charges.
- An individual being charged for procedures that weren't performed.
- A Provider making it a practice to waive all coinsurance responsibility or deductibles for certain procedures on patients.

In addition to fraud being a crime, you should understand that fraudulent claims have an adverse impact on the costs of the County's medical plan. Since the medical plan is funded by the County and its employees and retirees, false or fraudulent claims result in higher premium amounts for you and your co-workers, retirees, and the County.

The Florida Statute regarding False or Fraudulent Insurance Claims can be found at Florida Statutes 817.234. The Benefits Office will provide you with a copy of the statute upon written request at no charge.

## HOW TO RESPOND TO IMPROPER CHARGES OR SUSPECTED FRAUD

- If you believe that there is an issue with the billing or an EOB (Explanation of Benefits), you should contact BCBSFL Customer Service at (800) 664-5295.

- If you believe there has been an improper charge(s) on your bill after you receive the EOB (Explanation of Benefits) from BCBSFL and the EOB does not show that the charge(s) was corrected, you should contact the doctor (or their billing office) to correct the issue first and if the issue is not resolved, you should contact Employee Benefits at 305-292-4446.

- To report suspected insurance fraud or abuse, you should complete the form located on the BCBSFL website: http://www3.bcbsfl.com/wps/portal/bcbsfl/aboutus/reportfraud . The Benefits Office will provide you with a copy of the form upon written request at no charge.
  Individuals can also contact the Special Investigation Unit at 1-888-237-1501.

CARRIERS AND CONTACT INFORMATION:

**Medical Benefits (Administered by Blue Cross Blue Shield of Florida)**
Toll-Free Customer Service: (800)664-5295
Website: floridablue.com

**Prescription Drug Benefits (Administered by Envision Rx)**
Toll-Free Customer Service: (800) 361-4542
Website: www.envisionrx.com

**Vision Benefits (Insured and Administered by Vision service Plan Insurance Company)**
Toll-Free Customer Service: (800) 877-7195
Website: www.vsp.com

**Dental Benefits (Insured and Administered by Delta Dental**
Toll-free Customer Service: (800) 521-2651
Website: www.deltadentalins.com

**Group Life, Accidental Death and Dismemberment, and Supplemental Life**
**(Insured by Minnesota Life Insurance Company, A Securian Financial Group Affiliate)**
**(Administered by Ochs, Inc.)**
Toll-Free Life and AD&D Claims: (888)658-0193
Toll-Free Group & Supplemental Life Customer Service: (800)392-7295
Email: ochs@ochsinc.com

**Employee Assistance Program (Administered by Quantum Health Solutions of Florida)**
Toll-Free Customer Service: (877)747-1200
Services Available: 24 Hours Per Day/365 Days Per Year