

CITY OF SARASOTA

2017 BENEFIT HIGHLIGHTS



IMPORTANT CONTACT INFORMATION

City of Sarasota	Contact Name	Contact Information
Human Resources	Dominique Anderson	(941) 951-3661 Dominique.anderson@sarasotagov.com
Service	Provider	Contact Information
Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Health Reimbursement Account	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Prescription Drug Coverage & Mail-Order Program	Cigna Home Delivery Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
Employee Health Center	City of Sarasota	Customer Service: (877) 423-1330 www.carehere.com
Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Vision Insurance	OptiCare/Envolve	Customer Service: (800) 368-4790 www.opticare.com
Legal Protection Plan	ARAG	Customer Service: (800) 247-4184 www.araglegalcenter.com Access Code: 11254cos
FSA Administrator	Wage Works	Customer Service: (855) 428-0446 Claims Fax: (855) 291-0625 www.wageworks.com
Basic Life and AD&D Insurance	Standard Insurance Company	Customer Service: (800) 348-3226 Sarasota Benefits Office For Retirees: (941) 951-3630 www.thestandard.com
Supplemental Insurance	Trustmark	Customer Service: (800) 918-8877
Employee Assistance Program	Sarasota Memorial Health	Customer Service: (941) 917-1240 or (800) 425-7764 www.smh.com

The City reserves the right to modify, revoke, suspend, terminate or change the program, in whole or in parts, at any time. This is a Benefits Highlight Summary and not a contract. All benefits are subject to the provisions and exclusions of the master contract.

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Introduction

The City of Sarasota provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to the City's Personnel Policies, applicable Union Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources using the contact information provided. Information and descriptions provided are for the specific plan year and should not be construed as a contract.

Notices

COBRA Continuation of Medical Coverage Benefits

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

Medicare Part D Creditable Coverage

The City of Sarasota prescription drug coverage(s) are considered Creditable Coverage under Medicare Part D. If you or your dependents are or will be eligible for Medicare, you may obtain more information by requesting a Medicare Part D Disclosure of Creditable Coverage Notice.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

This provision provides employees and dependents a special enrollment right in group health plan coverage without having to wait for an open enrollment period for a loss of eligibility or becoming eligible for premium assistance under CHIP or Medicaid if requested within 60 days.

More information is available on the above notices by contacting Human Resources.

Medical Insurance

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for each Medical Plan Option available on our website at <http://sarasotagov.org/HR/Benefits.cfm>, are provided as a supplement to this booklet. These summaries are an important item in understanding your benefit options. You may request a printed copy of the SBC documents by contacting Human Resources, 111 South Orange Avenue, Room 204, Sarasota, FL 34236; (941) 951-3630 or by email at dominique.anderson@sarasotagov.com.

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the actual group certificate of coverage can be reviewed and obtained by contacting Human Resources.

If you have any questions about the plan offerings or coverage options, please contact Human Resources at (941) 951-3630.

Group Insurance Eligibility

The City's benefit plan year is January 1st through December 31st.

Eligibility

- **Employees** are eligible to participate in the City's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the 1st of the month following the Date of Hire. For example, if you are hired on April 11th, your coverage will be effective on May 1st.
- **City Commissioner's** coverage will be effective the day they are sworn in.
- **Retiree's** coverage will be effective the date of retirement.

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Termination

If you separate employment from the City, **insurance will end at midnight the day in which the separation occurred.**

Dependent Eligibility

A dependent is defined as the participant's legal spouse or domestic partner and dependent child(ren) of the participant or domestic partner. When a dependent is no longer a legal spouse, this is a qualified event as defined on Page 3, and they are no longer an eligible dependent and cannot remain on the plan. Dependent children may be covered through the end of the calendar year in which the child reaches age 26. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A child placed for adoption
- A stepchild
- A foster child
- Newborn dependent of a dependent up to 18 months
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Eligibility Age Requirements

Over-age Dependents may be covered by the medical and dental plans through the end of the calendar year in which the child turns age 26.

Medical and dental coverage may continue to the end of the calendar year in which the dependent reaches the age of 30, if the dependent is:

- Unmarried with no dependents; AND
- A Florida resident, or full-time or part-time student; AND
- Otherwise uninsured; AND
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is handicapped.

Domestic Partner

Domestic Partners may be eligible to participate in the City's group insurance plans and will be required to complete a Declaration of Domestic Partnership that must be completed in the Human Resources Department. The IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependents of a domestic partner are required to pay "imputed income tax" on premium deductions and should consult their tax expert. **The establishment of a Domestic Partnership is not a Qualifying Event under Section 125 of the Internal Revenue Code.** Please contact Human Resources for more information.

Spousal/Domestic Partner Surcharge

If a City employee or retiree carries his/her spouse or domestic partner on their medical coverage and the spouse/domestic partner is employed with access to insurance coverage through their employer AND declines that coverage, the City employee will be charged \$23.08 per biweekly pay period, or if a retiree \$50/month, in order to carry that spouse/domestic partner on the City's coverage as Primary. If your spouse/domestic partner is covered by Medicare as primary, this surcharge would not apply. A Spousal Surcharge form must be completed and submitted with enrollment forms to the Human Resources Department.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if the dependent is:

1. Physically or mentally disabled and incapable of self-sustaining employment by reason of mental retardation or physical handicap; AND
2. Is otherwise eligible for coverage under the group medical plan; AND
3. Coverage began prior to the age of 19; AND
4. Dependent has been continuously insured.

Proof of disability will be required upon request. Please contact Human Resources if further clarification regarding group insurance eligibility is required.

Taxable Dependents

Employees covering adult children under their medical insurance may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, imputed income for the value of the applicable adult child's coverage for the coverage period must be reported on the employee's W-2. Imputed income is the dollar value of insurance coverage attributable to covering the adult child. There is no imputed income if an adult child is eligible to be claimed as a dependent for federal income tax purposes on the employee's tax return. Check with Human Resources for further details if you are covering an adult child who will turn 27 any time in the upcoming calendar year or for more information.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

Premiums for medical, dental, vision insurance, and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made **ONLY** during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, if the event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Examples of Qualifying Events

- You get married or divorced
- You have a child, gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or dependent(s) terminate or start employment
- An increase or decrease in your work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60-day notification period).
- Becoming eligible for State premium assistance under Medicaid or CHIP (60-day notification period).

Please note: The forming of a Domestic Partnership, in and of itself, is not considered a qualifying event per IRS Code, Section 125.

IMPORTANT

If you experience a qualifying event, **you must contact Human Resources within 30 days of the qualifying event** to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place on date of the qualifying event. Any cancellations will be processed on the date that coverage ends. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event." Occurrence of a Qualifying Event during the plan year does not allow for change of Plan type.

Qualifying events allow for adding or dropping coverage for you or your dependents in your current plan only.

Employee Health Center

237 Payne Parkway, Unit 101
Sarasota, Florida 34237

To schedule an appointment please call: (877) 423-1330
or visit www.carehere.com

Access Code: SEHC2

HOURS OF OPERATION

Monday	Tuesday	Wednesday	Thursday	Friday
7 am – 4 pm (closed Noon–1 pm)	7 am – 4 pm (closed Noon–1 pm)	6 am – 4 pm (closed Noon–1 pm)	7 am – 4 pm (closed Noon–1 pm)	7 am – 4 pm (closed Noon–1 pm)
No Lab Appts on Monday	Lab Appts 7-10 am	Lab Appts 6-10 am	Lab Appts 7-10 am	No Lab Appts on Friday

The Sarasota Employee Health Center (SEHC) is available to employees, retirees and their dependents enrolled in the City’s medical insurance plan. It is completely voluntary and private so you can be sure that your medical information will not be shared with your employer. The SEHC can serve you in several ways to help lower your out of pocket costs and improve your health such as short wait times to be seen by the doctor, no co-pays or deductibles. Spouses and dependents (age 12 and over) are included as long as they are covered on your medical insurance plan and on-site medications are also dispensed at no charge once prescribed by the facility.

The SEHC provides the care you and your family need for all non-emergency illnesses, at no cost to you for the visit.

Services such as:

- Primary Care
- Well Woman Visits
- Prescription dispensing
- Labs performed on-site
- ECG’s
- Health Risk Assessments
- Health Coaches

To schedule an appointment call (877) 423-1330 or visit www.carehere.com to see the next available time.

Active Employee Medical Insurance Premiums for 2017

The City provides coverage, administered by Cigna, for eligible employees and their dependents. The costs per pay period for coverage are listed in the premium table below. **For information about your medical plan, please refer to the Summary of Benefits and Coverage (SBC) on our website at <http://sarasotagov.org/HR/Benefits.cfm>.**

The Summary of Benefits and Coverage (SBC), provided in addition to this Benefits Highlights Booklet, is your primary source of information regarding your Cigna medical plans. The information contained in this Booklet regarding your medical plans is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan, please contact Cigna's Customer Service at (800) 244-6224.

Consumer Driven Health Plan (CDHP)

Tier of Coverage	Teamster/Non-Represented Bi-Weekly
Single	\$0.00
Plus One	\$75.00
Family	\$150.00

COBRA Rates (CDHP)

Tier of Coverage	Monthly
Single	\$564.48
Dependent Age 26-30*	\$564.48
Plus One	\$1,333.97
Family	\$2,003.19

**Deduction per month (in addition to any other deduction) for each dependent Age 26-30 from the end of the calendar year after the dependent turns 26.*

Open Access Plus Plan (OAP)

Tier of Coverage	Teamster/Non-Represented Bi-Weekly
Single	\$22.00
Plus One	\$164.24
Family	\$196.88

COBRA Rates (OAP)

Tier of Coverage	Monthly
Single	\$682.76
Dependent Age 26-30*	\$682.76
Plus One	\$1,365.52
Family	\$2,389.66

**Deduction per month (in addition to any other deduction) for each dependent Age 26-30 from the end of the calendar year after the dependent turns 26.*

NOTE: Rates for Plans for PBA represented will remain static until negotiated.

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Termination of Coverage: If you separate employment from the City, coverage will end at midnight the day in which the separation occurs.

Retiree Medical Insurance Premiums for 2017

The City provides coverage, administered by Cigna, for eligible retirees and their dependents. The costs per month for coverage are listed in the premium tables below. **For information about your medical plan, please refer to the Summary of Benefits and Coverage (SBC) on our website at <http://sarasotagov.org/HR/Benefits.cfm>.**

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Consumer Driven Health Plan (CDHP)

Tier of Coverage	Retiree (Pre-1993 Hire) Monthly	Retiree (Post 10/1/93 Hire) and Surviving Spouse Monthly
Single	\$0.00	\$564.48
Plus One	\$617.75	\$1,333.97
Family	\$1,160.29	\$2,003.19

Open Access Plus Plan (OAP)

Tier of Coverage	Retiree (Pre-1993 Hire) Monthly	Retiree (Post 10/1/93 Hire) and Surviving Spouse Monthly
Single	\$116.07	\$682.76
Plus One	\$669.10	\$1,365.52
Family	\$1,362.11	\$2,389.66

Medical Insurance: Consumer Driven Health Plan (CDHP) At-A-Glance

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Network	Consumer Driven Health Plan	
	In Network	Out of Network
Calendar Year Deductible (CYD)		
Individual	\$2,500	\$5,000
2 Member Family	\$5,000	\$10,000
3 or More Member Family	\$7,500	\$15,000
Physician Office Visits	In Network	Out of Network**
Primary Care Physician (PCP)*	\$20 Copay	40% After CYD
Specialists (No Referral Required)	\$35 (CCN) / \$50 (Non-CCN)	40% After CYD
Emergency Services	In Network	Out of Network**
Emergency Room (Waived if Admitted)	\$250 Copay	
Urgent Care Facility	\$75 Copay	
Diagnostic Services	In Network	Out of Network**
Clinical Lab (Blood Work) at Independent Facility*	20% After CYD	40% After CYD
X-rays at Independent Facility*	20% After CYD	40% After CYD
Advanced Imaging (MRI, PET, CAT, MRA) Independent Facility*	20% After CYD	40% After CYD
Prescription Drugs (Rx)	In Network	Out of Network**
Tier 1 – Generic*	\$5 Copay	Not Covered
Tier 2 – Preferred Brand Name	\$35 Copay	
Tier 3 – Non-Preferred Brand Name	\$70 Copay	
Tier 4 –Specialty Drugs	\$250 Copay	
Mail-Order Program (90 Day Supply)	2.5x Retail Copay	
Hospital	In Network	Out of Network**
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	40% After CYD
Physician Services at Outpatient Hospital or Surgical Center	20% After CYD	40% After CYD
Mental Health / Alcohol & Substance Abuse	In Network	Out of Network**
Inpatient	20% After CYD	40% After CYD
Outpatient Facility	No Charge	40% After CYD
Physician Office Visit	\$35 (CCN)/ \$50 (Non-CCN)	40% After CYD
Coinsurance (When Applicable)	In Network	Out of Network
Plan Reimbursement	80%	60%
Member Responsibility	20%	40%
Out-of-Pocket Maximum	In Network	Out of Network
Individual	\$6,500	\$90,000
2 Member Family	\$10,500	\$90,000
3 or More Member Family	\$13,200	\$90,000
What Applies to the Out-of-Pocket Maximum	Deductibles, Coinsurance, Copays & Rx	

***These services are provided at no cost when visiting, or by referral out from, the Sarasota Employee Health Center**

Calendar Year Deductible (CYD) must be met before any co-insurance applies.

****Out-Of-Network Balance Billing**

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

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Medical Insurance: Open Access Plus Plan (OAP) At-A-Glance

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Network	Open Access Plus (OAP)	
Calendar Year Deductible (CYD)	In Network	Out of Network
Individual	\$750	\$1,500
2 Member Family	\$1,500	\$3,000
3 or More Member Family	\$2,250	\$4,500
Physician Office Visits	In Network	Out of Network**
Primary Care Physician (PCP)*	\$20 Copay	40% After CYD
Specialists (No Referral Required)	\$35 (CCN) / \$50 (Non-CCN)	40% After CYD
Emergency Services	In Network	Out of Network**
Emergency Room (Waived if Admitted)	\$250 Copay	
Urgent Care Facility	\$75 Copay	
Diagnostic Services	In Network	Out of Network**
Clinical Lab (Blood Work) at Independent Facility*	\$10 Copay	40% After CYD
X-rays at Independent Facility*	\$10 Copay	40% After CYD
Advanced Imaging (MRI, PET, CAT, MRA) Independent Facility*	\$250 Copay Per Scan	40% After CYD
Prescription Drugs (Rx)	In Network	Out of Network**
Tier 1 – Generic*	\$5 Copay	Not Covered
Tier 2 – Preferred Brand Name	40% of Cost, \$35 Min. & \$75 Maximum	
Tier 3 – Non-Preferred Brand Name	60% of Cost, \$70 Min. & \$100 Maximum	
Tier 4 – Specialty Drugs	\$250 Copay	
Mail-Order Program (90 Day Supply)	2.5x Retail Copay	
Rx Maximum Out-Of-Pocket	In Network	Out of Network**
Individual / 2 Member Family / 3 or More Member Family	\$4,100 / \$5,700 / \$5,700	\$90,000
Hospital	In Network	Out of Network**
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	40% After CYD
Physician Services at Outpatient Hospital or Surgical Center	20% After CYD	40% After CYD
Mental Health / Alcohol & Substance Abuse	In Network	Out of Network**
Inpatient	20% After CYD	40% After CYD
Outpatient Facility	No Charge	40% After CYD
Physician Office Visit	\$35 (CCN)/ \$50 (Non-CCN)	40% After CYD
Coinsurance (When Applicable)	In Network	Out of Network
Plan Reimbursement	80%	60%
Member Responsibility	20%	40%
Medical Maximum Out-of-Pocket	In Network	Out of Network
Individual	\$2,500	\$90,000
2 Member Family	\$5,000	\$90,000
3 or More Member Family	\$7,500	\$90,000
What Applies to the Out-of-Pocket Maximum	Deductibles, Coinsurance & Copays	

*These services are provided at no cost when visiting, or by referral out from, the Sarasota Employee Health Center

**Out-Of-Network Balance Billing *Calendar Year Deductible (CYD) must be met before any co-insurance applies.*

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

Wellness Incentive Program

The City of Sarasota is committed to wellness and health and continues to adopt plans to encourage healthy behaviors. The City’s benefit program includes incentives for covered members over the age of 19 (maximum of two per family) for each health target achieved. Eligible participants in this program include City employees, retirees and one of their dependents over the age of 19.

This program is completely voluntary. If you choose to participate you will need to go to your Primary Care Physician or make an appointment at the Employee Health Center for blood work. Once your blood work is completed please have your doctor complete the worksheet available in Human Resources. At that point you and your doctor can determine how many targets you have achieved. The number of targets achieved need to be marked on the Employee Wellness Target Form and returned to Human Resources.

Wellness Targets

Measurement	Targets
<u>Weight Measurement</u> a. Waist Circumference OR b. Body Mass Index	Men - 40” or less Women - 35” or less 25 or Less
Tobacco Use	No Use Detected
Blood Sugar	Less than 100 mg/dl
Triglycerides	150 mg/dl or less
Blood Pressure	Systolic-130 or less Diastolic-85 or less
Total Cholesterol	200 mg/dl or less OR Cholesterol/HDL ratio of 4 or less

Members may achieve any or all targets. The incentive is calculated on a maximum of six targets. You may enroll in the program one time per year during Open Enrollment. If you choose to participate in the program, each member (up to a maximum of two covered members over the age of 19, one must be the employee or retiree) must certify the outcomes achieved through your primary care physician.

Incentive dollars will be deposited into your Health Reimbursement Account (HRA) to be used for out of pocket medical expenses.

Wellness Results: How it works

All participants must visit their Primary Care Physician with the Employee Wellness Target Form. This program is employee-driven meaning you and your dependent will need to work with your Primary Care Physician to complete the weight measurement and blood pressure during your office visit and ask them for a laboratory order for blood work that will measure the other wellness targets. You and your dependent will then need to complete your laboratory visit for your blood work.

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Wellness Incentive Program *(Continued)*

If you are completing this through your Primary Care Physician, ask your Physician to complete the measures on the Wellness Target Form once your blood work is complete and the results have been sent back to them. **The Human Resources Department does not want to receive any medical information from your Primary Care Physician, only the number of targets met.**

The Employee Wellness Target Form must be completed by your Primary Care Physician and returned via fax or **submitted to the Human Resources Department.**

The information on the Employee Wellness Target Form will be used to determine the number of Wellness Credits you and your dependents will receive. The Human Resources Department will use this information and calculate the amount to be deposited into your HRA account. Each target will be worth \$100 deposited into the HRA, regardless of plan choice. *If the primary member completes their Wellness activities within their birth month, an additional \$50 will be deposited into your HRA.*

This Wellness program may be subject to changes and revisions annually.

New Hires may participate in the Wellness Incentive Program. You must complete your blood work and follow up physician's appointment by the end of the first month your coverage becomes effective. Total incentive dollars earned will be pro-rated for the portion of the year that coverage is in effect.

Health Reimbursement Account

The Summary of Benefits and Coverage (SBC), located on our website at <http://sarasotagov.org/HR/Benefits.cfm>, is your primary source of information regarding your Cigna medical plans. The information contained in this Booklet regarding your medical plans is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan, please contact Cigna's Customer Service at (800) 244-6224.

Cigna

Customer Service: (800) 244-6224

www.cigna.com

The City offers employees the opportunity to open a Health Reimbursement Account (HRA). The City will be using Cigna for the administration of the Health Reimbursement Account (HRA). A Health Reimbursement Account (HRA) is an employer-established account into which your incentive dollars will be deposited. Your wellness incentive dollars will go into this account for your use throughout the year for qualified medical expenses for you and your covered dependents. Qualified medical expenses are such things as deductibles, copays, coinsurance, and pharmacy expenses. These funds can only be used for expenses incurred during the 2017 calendar year. The HRA monies provide tax-free funds to cover those expenses incurred under the medical plan.

HRA Funding Allotment

1. Eligible expenses under an HRA plan are determined by the City and include:
 - Health insurance deductibles
 - Coinsurance and co-pays, including Pharmacy
 - Other expenses included in IRS Publication 502 - Medical Expenses as eligible or qualified expenses
2. Ineligible expenses include premium reimbursement, dental, vision care outside of the health plan and expenses or services not covered by the health plan.
3. Eligible expenses must be incurred by the employee and/or eligible members of the employee's family, and take place within the benefit plan year. Any claims incurred within a calendar year must be submitted by March 31 of the following year in order to qualify for reimbursement.
4. HRA money is not paid out when the member leaves employment.
5. HRA money can transfer when the eligible member transitions from an active employee to a retiree and remains covered by the employer's health plan. The transition must happen within the benefit plan year. Up to \$250 of the remaining funds at the end of the plan year may be rolled over for use in the next plan year.
6. The City's HRA may be used in conjunction with a Flexible Spending Account (FSA). The HRA will be established to cover eligible expenses automatically. A member cannot get reimbursed for the same eligible expenses under the HRA and FSA.

Do I still need to keep my receipts?

Yes. During the year, you should keep all receipts and documentation for prescriptions and medical related expenses for all transactions so that you have them if needed to verify a claim for Cigna or for IRS taxes. If asked to produce documentation, a valid Explanation of Benefits (EOB) and receipt of payment for the services rendered will be sufficient.

How to File a Paper Claim

Employees may submit claim forms to Cigna with an Explanation of Benefits form from the insurance carrier or receipts for eligible medical services throughout the plan year. Claim forms can be submitted via fax or mail, which is indicated on the claims form, or electronically at mycigna.com.

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How to Locate a Provider

To search for a participating provider, contact Customer Service or go to www.cigna.com, and select the “Find a Doctor” tab. Click “If Your Insurance is Offered Through Work or School” and choose “**Open Access Plus Network**” for your plan type, and hit “Choose”. Then, complete the additional search criteria and click “Search”.

Other Available Plan Resources

mycigna.com

mycigna.com is the 24-hour secure member self-service website that provides access to many self-service choices and health related information. Log on to mycigna.com for personalized services including:

- Verify your personal information
- Review your coverage
- Search “Frequently Asked Questions”
- Find network providers
- Download forms
- View your claims
- Learn about discount programs
- Communicate with Customer Service
- Quicken health expense tracker
- Review Your HRA balance

24 Hour Help Information Hotline (800) 244-6224

The Cigna 24-Hour Health Information Line provides you access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do when your child has a fever in the middle of the night? Have you injured yourself and are not sure if you should seek treatment? There are over 1,000 topics in the Health Information Library that include FREE audio, video and printed information on aging, women’s health, nutrition, surgery and specific medical conditions to help you weigh the risks and advantages of treatment options. The call is FREE and strictly confidential.

Healthy Rewards

Cigna’s Healthy Rewards is provided to you automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to www.mycigna.com and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- Vision Care
- Lasik Vision Correction Services
- Fitness Club Discounts
- Nutrition Discounts
- Hearing Care
- Tobacco Cessation
- Alternative Medicine

The myCigna Mobile App

The myCigna Mobile App gives you an easy way to organize and access your important health information. Anytime. Anywhere. Download it today from the App StoreSM or Google PlayTM. With the myCigna Mobile App you can:

- Find a doctor, dentist or health care facility
- Access maps for instant driving directions
- View ID cards for the entire family
- Review deductibles, account balances and claims
- Compare prescription drug costs
- Speed-dial Cigna Home Delivery PharmacyTM
- Store and organize all important contact info for doctors, hospitals, and pharmacies
- Add health care professionals to contact list right from a claim or directory search
- Track your annual deductibles, maximum out of pocket totals and your FSA balance
- And, much more!

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Dental Insurance – PPO Plan

Cigna

Customer Service: (800) 244-6224

www.cigna.com or www.mycigna.com

The City offers dental insurance administered by Cigna. The cost per pay period are listed in the premium table below. A brief description of the Dental PPO Plan is below and a summary of the plan’s schedule of benefits is on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier’s benefit summary or contact Cigna.

Dental Insurance – Dental PPO Plan Premiums

Tier of Coverage	Teamster/Non-Represented Bi-weekly	PBA Union Bi-weekly
Employee Only	\$2.00	\$2.00
Employee + One	\$4.00	\$4.00
Employee + Family	\$6.00	\$6.00
Dependent Age 26-30*	\$35.00	\$35.00
Tier of Coverage	Retiree (Pre 10/1/93 Hire) Monthly	Retiree (Post 10/1/93 Hire) and Surviving Spouse Monthly
Retiree Only	\$0.00/\$4.34**	\$35.00
Retiree + One	\$8.67	\$65.00
Retiree + Family	\$13.00	\$95.00

*Deduction per month (in addition to any other deduction) for each dependent age 26 - 30 from the end of the calendar year after the dependent turns 26.

**Retirees who waive medical coverage, but remain on dental coverage, will be charged \$4.34/month for single coverage

In-Network Benefits

The Dental Preferred PPO Plan is an “open access” plan that allows you to receive services from any dental provider without selecting a Primary Dental Provider (PDP) and does not require referrals to specialists. In order to receive services, you can select any participating dental provider in the PPO Radius Network.

Out-of-Network Benefits

Providers who do not contract with insurance carriers because they do not accept their discounted rates are referred to as “non-participating” or “out of network.” Understanding how your insurance company pays for out-of-network services is important because you will usually pay more. The insurance company processes charges based on what it determines the “Usual, Customary and Reasonable (UCR)” charge is for a specific service. UCR or the “allowed amount” can be defined as the most common charge for a particular medical procedure performed in a specific geographic area. Since there is no contract in place between the insurance company and out-of-network provider, the provider may charge an amount higher than the UCR. The difference between the UCR amount and the provider’s higher charge is called “balance e billing.” **Balance billing is in addition to your deductible and coinsurance responsibility.**

How to Find a Provider

To search for a participating provider, contact Cigna’s Customer Service or visit www.cigna.com and select the “Find a Doctor” tab. Select the “If You Already Have A Cigna Plan” option, and log in or register for a MyCigna.com account. Once you create an account (or log into your existing account), you will be able to search for a participating **Total Cigna DPPO** provider.”

Calendar Year Deductible

This plan’s benefits begin once each covered member satisfies the \$50 deductible. The deductible is applied collectively for either in-network or out-of-network services or any combination of both. Once any 3 covered members in a family each satisfies the deductible, the deductible will then be considered met for all covered members in that family. Once you satisfy your annual deductible, your coinsurance responsibility will be based on the plan’s discounted fee schedule and will be determined by the type of services you receive as summarized in the table on the following page.

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Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the dental plan will pay for each covered member is \$1,500 for in-network and out-of-network services combined. Preventive services accumulate towards the benefit maximum.

Please Note the Following:

- Each member may receive up to 2 cleanings per year, when utilizing an in network provider, which must be scheduled 6 months apart.
- Teeth missing prior to coverage under the plan are not covered.
- Waiting periods and age limitations may apply to some services.

Dental Insurance: Dental PPO Plan At-A-Glance

Network	Total Cigna DPPO	
Calendar Year Benefit Maximum	In Network	Out of Network
Per Member	\$1,500	
Calendar Year Deductible (CYD)	In & Out of Network Combined	
Per Member	\$50	
Per Family	\$150	
Waived for Class I Services?	Yes	
Class I Services: Diagnostic & Preventative	In Network	Out of Network*
Routine Oral Exam (2 Per Year)	Plan Pays: 80% Deductible Waived	Plan Pays: 80% Deductible Waived <i>(Subject to Balance Billing)</i>
Routine Cleanings (2 Per Year)		
Bitewing X-rays (2 Per Year)		
Panoramic X-rays (One Every 3 Years)		
Complete X-rays (One Every 3 Years)		
Fluoride Treatments Annually up to Age 19		
Sealants Every 3 Years up to Age 14		
Space Maintainers (Non-Orthodontic Treatment)		
Class II Services: Basic Restorative	In Network	Out of Network*
Fillings (Amalgam and Composite)	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD <i>(Subject to Balance Billing)</i>
Routine Extractions		
Root Canal Therapy		
Periodontal Scaling - Entire Mouth		
Oral Surgery		
General Anesthesia		
Class III Services: Major Restorative**	In Network	Out of Network*
Bridges	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD <i>(Subject to Balance Billing)</i>
Crowns		
Dentures		
Class IV Services: Orthodontia**	In Network	Out of Network*
Lifetime Maximum	\$1,500	
Benefit	50% Coinsurance; No Deductible	50% Coinsurance; No Deductible

**Late entrant limitation will apply

For any dental work expected to cost \$200 or more, the plan will provide a “Pre-Determination of Benefits” upon the request of your dental provider. This will assist you with determining your approximate out-of-pocket costs should you have the dental work performed.

***Out-Of-Network Balance Billing**

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

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Vision Insurance: OptiCare/Envolv Vision Plan

OptiCare/Envolv

Customer Service: (800) 368-4790

www.opticare.com

Vision Insurance – Plan Premiums

The City offers vision insurance through OptiCare/Envolv. The vision insurance employee/retiree costs are provided in the premium table to the right, followed by a brief description of the plan below.

A summary of the plan's schedule of benefits is on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact OptiCare.

Tier of Coverage	Employee Cost Bi-Weekly
Employee Only	\$2.90
Employee + Family	\$6.98
Tier of Coverage	Retiree Monthly
Retiree Only	\$6.29
Retiree + Family	\$15.12

In-Network Benefits

The vision plan provides you and your covered dependents with coverage of routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered members can select any optometrist or ophthalmologist that participates in the **OptiCare Vision Plan Network**. At the time of service, routine vision examination services and basic optical needs will be covered as shown on the following summary. Cosmetic services and upgrades will be extra if chosen at the time of your appointment.

Out-of-Network Benefits

Covered members may also choose to receive services from vision providers who do not participate in the OptiCare Vision Network.

If so, the cost of the services received would be paid to that provider at the time of the scheduled appointment. OptiCare will then reimburse the covered members based on the plans out-of-network reimbursement schedule upon receipt of proof of services rendered.

How to Locate a Provider

To search for a participating provider, call Customer Service or go to www.opticare.com and select "Provider Search". Choose how would you like to search, and fill out search criteria choosing "**OptiCare Vision Plan**" in the Health Plan dropdown, and then "Search."

Calendar Year Deductible

There is no Calendar Year Deductible (CYD).

Calendar Year Benefit Maximum

There is no Out-of-Pocket Maximum. However, there are benefit reimbursement maximums for certain services per year.

Please Note the Following:

- Discount on frame cost over retail allowance.
- Additional savings on lens options including anti-reflective and scratch-resistant coatings.
- Discount on a second pair of eyeglasses once the funded benefit has been used. This discount is available through the network provider who sold the initial pair of eyeglasses.
- Discount off of the retail price for LASIK or PRK from network providers.

Vision Insurance: OptiCare/Envolve Vision Plan At-A-Glance

Services	In Network	Out of Network
Eye Exam	\$10 Copay	Up to \$38.50 Reimbursement
Materials	\$20 Copay	Plan reimburses member based on the type of service
Frequency of Services	In Network	Out of Network
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses	In Network	Out of Network
Single	Paid In Full After Copay	Up to \$37.50 Reimbursement
Bifocal		Up to \$55 Reimbursement
Trifocal		Up to \$90 Reimbursement
Frames	In Network	Out of Network
Basic, Preferred or Non-Preferred	\$150 Retail Allowance	Up to \$105 Reimbursement
Contact Lenses*	In Network	Out of Network
Non-Elective (Medically Necessary)	Paid In Full After Copay	Up to \$210 Reimbursement
Elective Lenses	\$150 Retail Allowance	Up to \$105 Reimbursement
Standard Fitting	Paid In Full After Copay	Up to \$26.60 Reimbursement
Specialty Fitting	\$75 Allowance; 20% Discount Over \$75	Up to \$52.50 Reimbursement

* Contact lenses are in lieu of spectacle lenses and a frame

Legal Protection Plan

Legal Protection Plan - ARAG

Customer Service: (800) 247-4184

www.araglegalcenter.com

Access Code: 11254cos

The City offers employees the opportunity to participate in a voluntary legal protection plan provided by ARAG. ARAG offers two plan levels. The Employee/Retiree costs are provided in the premium table to the right. Plan benefits include online resources, phone advice and face-to-face consultations with the attorney, and much more. To learn more about the plans please contact ARAG Customer Service.

Coverage Type	Employee Cost Biweekly	Retiree Cost Monthly
Ultimate Advisor	\$8.08	\$17.50
Ultimate Advisor Plus	\$10.62	\$23.00

By enrolling in the plan, participants will have direct access to attorneys who will provide services for a variety of situations that include (Ultimate Advisor Plus offers additional legal benefits indicated in bold with a (+) sign):

Civil Damage Claims (Defense)

- Civil Damage
- Pet-Related Matters

Real Estate Matters

- **Building Codes/Zoning Variances +**
- Buying/Selling a Home
- Foreclosure
- Home Improvement/Contractor Issues
- Neighbor Disputes/Easements
- Promissory Notes

Consumer Protection Issues

- Auto Repair
- Buying a New or Used Vehicle
- Consumer Fraud
- Consumer Protection for Goods or Services

Criminal Matters

- Juvenile Matters
- Misdemeanor Matters
- Parental Responsibilities

Debt-Related Matters

- **Bankruptcy (Chapter 7 & 13) +**
- Debt Collection Matters

Landlord / Tenant Matters

- Contracts/Lease Agreements
- Eviction
- Security Deposits
- Tenant Disputes with a Landlord

Family Law

- Adoption
- **Alimony (up to 8 hours) +**
- **Child Custody (up to 8 hours) +**
- **Child Support (up to 8 hours) +**
- **Divorce/Annulment/Separation (up to 15 hours) +**
- Guardianship/Conservatorship
- Name Change
- **Pre-marital Agreements +**

Government Benefits

- **Medicare/Medicaid Disputes +**
- **Social Security Disputes +**

• Veterans Benefits Disputes +

- Small Claims Court
- Small Claims Court Issues

Tax Issues

- Federal IRS Tax Audit
- Federal IRS Tax Collection

Traffic Matters

- Driver's License Suspension, Revocation and Restoration without DUI

Wills and Estate Planning

- Codicil (amendment to a Will)
- Complex Will
- Durable/Financial Power of Attorney
- **Estate Administration with Parents (limited) +**
- Health Care Power of Attorney
- **Irrevocable Trust +**
- Living Will
- Standard Will

Flexible Spending Accounts

Wage Works

Customer Service: (855) 428-0446

Claims Fax: (855) 291-0625

www.wageworks.com

The City offers Flexible Spending Accounts (FSA) administered through Wage Works for active employees.

If you have predictable medical expenses for yourself or your family, such as deductibles and copays, or any work-related day care expenses, FSAs may be right for you. FSAs allow you to set aside money for reimbursement of medical and day care expenses you regularly pay. The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA. During the year, you have access to this account for reimbursement of some expenses that are not covered by insurance. An FSA not only results in a substantial tax savings, it also increases your spending power. There are two types of FSAs:

Health Care Reimbursement Account	Dependent Care Reimbursement Account
<p>This account allows you to set aside up to an annual maximum of \$2,550. This money will not be taxable income to you and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs for you or your qualified dependents. Employees can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).</p> <p>Examples of common expenses that qualify for reimbursement are listed below.</p> <p>NOTE: The entire Health Care FSA election is available to you on the first day coverage is effective.</p>	<p>This account allows you to set aside up to an annual maximum of \$5,000 if you are single or married and file a joint tax return (\$2,500 if you are married and file a separate tax return) for work-related day care expenses. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and adults.</p> <p>Please note that if your family's annual income is over \$20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be:</p> <ul style="list-style-type: none"> • a child under the age of 13, or • a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household. <p>NOTE: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for dependent care expenses.</p>

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

- Ambulance service
- Chiropractic care
- Dental fees/Orthodontic fees
- Diagnostic tests/Health screenings
- Doctor fees
- Drug addiction/Alcoholism treatment
- Experimental medical treatment
- Eyeglasses/Contact lenses (corrective)
- Hearing aids and exams
- Injections & vaccinations
- Lasik surgery
- Mental healthcare
- Nursing services
- Optometrist fees
- Physician office visits
- Prescription drugs
- Sunscreen
- Wheelchairs

***Note: Effective 1/1/2011 over-the-counter items are no longer a qualified expense, unless prescribed by a physician. Log on to <http://www.irs.gov/publications/p502/index.html> for additional details regarding qualified and non-qualified expenses.**

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- You may carry over up to \$500 of unused funds from your Healthcare Reimbursement Account into the next plan year after a plan year ends and all claims have been filed. Dependent Care funds CANNOT be carried over.
- After a plan year ends and all claims have been filed any unused funds cannot be returned to you or carried forward to the next plan year, with the exception of the \$500 carry over that may be allowed for the Healthcare Reimbursement Account.
- You can enroll in either or both FSAs during open enrollment period, a qualifying event or new hire eligibility only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- You have a run out extension at the end of the plan year (until March 30th) to claim reimbursement for eligible expenses incurred during your period of coverage within the plan year (January 1st - December 31st).
- Domestic Partners are not eligible as federal law does not recognize them as a qualified dependent.

NOTE: Be conservative when estimating your medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and after all claims have been filed, cannot be returned to you or carried forward to the next plan year, with the exception of the \$500 carry over that may be allowed for the Healthcare Reimbursement FSA. This is known as the "USE IT OR LOSE IT" rule.

Filing a Claim

The IRS requires FSA participants to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year. To file a claim, you must submit your completed claim form and include a copy of the receipt as proof of the expense. Once completed, you may submit your claim either by mail, fax, or electronically.

Mail to: Wage Works

Claims Administrator - FBWW Or Fax to: (855) 291-0625 Or electronically at:

PO Box 14326 www.wageworks.com

Lexington, KY 40512

Debit Card

FSA participants will receive a debit card for payment of eligible medical expenses. Participants are able to pay for most qualified services and products at the point of sale versus paying out of pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities and most pharmacy retail outlets. Some expenses may require documentation to be submitted.

Active Employee Basic Life and AD&D Insurance

Standard Insurance Company
 Customer Service: (800) 348-3226 or
 Benefit Office: (941) 951-3630

Basic Term Life Insurance

The City provides a Basic Life insurance benefit to all eligible employees at no cost. All eligible full-time employees working a minimum of 30 hours per week are covered for a benefit amount of \$10,000.

Basic Accidental Death & Dismemberment Insurance

The City provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit, and a partial benefit is also payable based on the schedule below.

Always remember to keep your beneficiary forms updated.
You may update your beneficiary at any time through Human Resources.

Voluntary Life Insurance

Eligible employees may elect to purchase additional life insurance on a voluntary basis through Standard Insurance Company. This coverage may be purchased in addition to the Basic Term Life coverage. Voluntary Life insurance offers coverage for yourself, your spouse and/or child(ren) at different benefit levels.

Voluntary Life	
Employee Age	Biweekly Rates per \$10,000
<30	0.28
30-34	0.42
35-39	0.46
40-44	0.92
45-49	1.66
50-54	2.72
55-59	4.57
60-64	5.54
65-69	8.54
70-74	9.99
75+	13.27

New Hires: There is a 1 time “special enrollment” to purchase voluntary employee life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI) up to the guaranteed issue amount of \$100,000.

Voluntary Life insurance is issued without medical certification at the time of initial eligibility as a new hire. Additional coverage applied for during open enrollment is not guaranteed issue and requires medical certification.

- Units can be purchased in increments of \$10,000 from a **minimum of \$10,000** to a maximum of \$500,000. Up to \$100,000 with no Medical Underwriting.
- **Premium calculation:**
 Elected Coverage ÷ \$10,000 x Employee Rate (see table) = Biweekly Premium.
- Premiums are not locked in and increase when age bands are crossed.

Voluntary Spouse Life Insurance

- An employee **must** participate in the voluntary plan for his/her spouse to participate.
- Units can be purchased in the amounts of \$5,000 or \$10,000. Coverage cannot exceed 50% of the employee’s voluntary coverage amount.

Voluntary Dependent Life Insurance

- An employee **must** participate in the voluntary plan for his/her dependent children to participate.
- Coverage in the amount of \$2,500 or \$5,000 can be purchased for children 0 months to age 20 (until 24th birthday if full-time student).

Voluntary Spouse/Dependent Life Insurance Premium Cost

- Spouse: Option \$5,000 or \$10,000 – Bi-weekly Spouse rate is \$0.74 or \$1.47
- Child: Option \$2,500 or \$5,000 – Bi-weekly Child rate \$0.23 or \$0.46

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Retiree Basic and Voluntary Life Insurance

Standard Insurance Company
Customer Service: (800) 348-3226 or
Benefit Office: (941) 951-3630

Basic Term Life Insurance

Eligible retirees are covered by \$3,000 of Basic Term Life coverage.

Voluntary Life Insurance

Voluntary Life insurance is **only available if additional voluntary term life coverage with Standard Insurance Company is in force at the time of retirement.** Retirees may not add additional insurance on themselves through Standard Life at a later date. Voluntary Life insurance offers coverage for yourself, your spouse and/or child(ren) at set benefit levels.

- Units can be purchased for the retiree in the amounts of \$7,000 or \$17,000.
- Premium are based on age and coverage level.
- Premiums are not locked in and increase when age bands are crossed.

Voluntary Spouse/Dependent Child Life Insurance

May be purchased in the amount of \$1,500 for spouse and/or dependent children for a flat monthly rate of \$1.38.

Retiree Voluntary Life		
Retiree Age	Monthly Rates per \$7,000	Monthly Rates per \$17,000
<30	0.49	1.19
30-39	0.84	2.04
40-44	1.54	3.74
45-49	2.73	6.63
50-54	4.41	10.71
55-59	7.56	18.36
60-64	8.75	21.25
65-69	13.65	33.15
70-74	23.31	56.61
75 & over	40.25	97.75

Supplemental Insurance

Trustmark

Customer Service: (800) 918-8877

Trustmark offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid via payroll deduction for active employees. Trustmark pays money directly to you, regardless of what other insurance plans you may have. To learn more about these plans, you may schedule a personal appointment with your Agent during open enrollment.

- Universal Life
- Term Life
- Disability
- Cancer
- Critical Illness

Employee Assistance Program

Sarasota Memorial Health Care System

24-Hour Crisis Line: (941) 917-1240 or (800) 425-7764

www.smh.com

The City cares about your well-being on and off the job and provides all eligible active employees and each member of your family an Employee Assistance Program (EAP) through SMH at no cost. The EAP provides professional counseling for a variety of problems that affect your quality of life. All EAP counselors are professionally trained and are certified and licensed in their fields.

Master-level counselors are available 24 hours a day, 7 days a week, at (941) 917-1240 or (800) 425-7764. The EAP is strictly confidential. The EAP also allows for 4 face to face in-person sessions per member per occurrence with a counselor for short term problem resolution. Conditions that require a long-term treatment may be referred to your medical plan. The EAP gives you a comfortable and safe place to turn for help with all kinds of problems such as:

- Stress Management
- Parenting Problems
- Marital Problems
- Relationship Issues
- Advocate
- Substance Abuse
- Critical Incident Debriefing
- Child Care
- Elder Care
- Financial Referrals
- Credit Counseling
- Legal Referrals
- Crime Victim

Are your services confidential?

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

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the City of Sarasota (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on January 1.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. City of Sarasota requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered.

For example, a health care provider who provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

The City reserves the right to modify, revoke, suspend, terminate or change the program, in whole or in parts, at any time. This is a Benefits Highlight Summary and not a contract. All benefits are subject to the provisions and exclusions of the master contract.

Privacy Practices (Continued)

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of the City of Sarasota for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances.

You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Privacy Practices (Continued)

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Stacie Mason
City of Sarasota
111 South Orange Ave.
Sarasota, FL 34236
941-951-3634
Email: Stacie.Mason@sarasotagov.com

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services - Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

In the event that there may be a discrepancy between the contents of this booklet and the Plan Document, the Plan Document will prevail.

Appendix

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084</p>	<p align="center">OREGON – Medicaid</p> <p>Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075</p>
<p align="center">NEBRASKA – Medicaid</p> <p>Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633</p>	<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>	<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300</p>

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SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
<p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p>Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473</p>
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
<p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p>Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability</p>
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
<p>Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414</p>	<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
VERMONT– Medicaid	WYOMING – Medicaid
<p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p>Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p>

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

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

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

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