

City of *Sarasota*



2012 EMPLOYEE BENEFIT HIGHLIGHTS

IMPORTANT CONTACT INFORMATION

City of Sarasota	Contact Name	Contact Information
Human Resources	Stacie Mason	(941) 951-3630 stacie.mason@sarasotagov.com
Service Providers	Contact Name	Contact Information
Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Employee Assistance Program (EAP)	Sarasota Memorial Health	Customer Service: (941) 917-1240 or (800) 425-7764 www.smh.com
Employee Health Center	City of Sarasota	Customer Service: (877) 432-1330 www.carehere.com
FSA Administrator	FBMC / Wage Works	Customer Service: (800) 342-8017 Claims Fax: (866) 440-7145 www.myfbmc.com
Health Insurance	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Life Insurance	Standard Insurance Company	Customer Service: (800) 348-3226 Sarasota Benefits office For Retirees: (941) 951-3634 www.thestandard.com
Legal Protection Plan	ARAG	Customer Service: (800) 247-4184 www.araglegalcenter.com Access Code: 11254cos
Prescription Drug Coverage & Mail Order Program	CIGNA Home Delivery Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
Supplemental Insurance	Trustmark	Customer Service: (800) 918-8877
Vision Insurance	OptiCare	Customer Service: (877) 615-7732 www.opticarevisionplans.com/groups/cos

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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 telephone numbers under each benefit description heading or contact Human Resources using the following contact information provided.

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 medical plans such as health 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) is 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.

Notification of Grandfather Status

The City has determined the health plans offered are a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

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

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.

Termination

If you separate employment from the City, insurance will end 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. 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

Group Insurance Eligibility *(continued)*

Dependent Eligibility Age Requirements

Eligibility requirements for eligible Over-age Dependents have been eliminated for group medical insurance. Over-age Dependents may be covered by the medical plans through the end of the calendar year in which the child turns age 26.

Medical 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.

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.

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. 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 will see the insurance premium deductions are required to pay "imputed income tax" on subsidy amounts and should consult their tax expert. 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.

Taxable Dependents

Employees covering adult children under their health insurance plan 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 employees 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 include the following:

- 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
- Gain or loss of eligibility for Medicaid or CHIP coverage (60 day notification period)

Please note: The forming of a Domestic Partnership, in and of itself, is not considered a qualifying event.

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 the first of the month following the qualifying event, except for newborns which are effective on the date of birth. Any cancellations will be processed at the end of the month, except coverage terminates the date following a death. 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, i.e. from a Gold Plan to a Teal Plan. Qualifying events allow for adding or dropping coverage for you or your dependents in your current plan only.

Health Insurance: CIGNA OAPIN – Gold Plan

CIGNA
 Customer Service: (800) 244-6224
 www.cigna.com or www.mycigna.com

Cigna Home Delivery Pharmacy
 Mail Order Program
 Customer Service: (800) 835-3784
 www.mycigna.com

Cigna is the City’s administrator of claims for medical, dental and pharmacy benefits. The health coverage employee/retiree costs are provided in the premium table below, followed by a brief description of the Cigna OAPIN - Gold Plan. A summary of the plan’s schedule of benefits is on the following page. For detailed coverages, exclusions and stipulations, please refer to the summary plan description or contact Cigna.

Gold Plan

Tier of Coverage	Teamster/Non-Represented Bi-weekly	** PBA Union Bi-weekly - 2011 Rates
Employee Only	1% of Base Annual Salary / 26	\$24.00
Employee + One	\$139.74	\$137.68
Employee + Family	\$168.71	\$166.22
Dependent Age 26-30*	\$624.75/month	\$594.01/month
Tier of Coverage	Retiree (Pre 10/1/93 Hire) Monthly	Retiree (Post 10/1/93 Hire) and Surviving Spouse Monthly
Retiree Only	Up to \$106.21 based on pension	\$624.75
Retiree + One	\$302.78	\$1,249.45
Retiree + One with Medicare A & B	\$151.39	Not Applicable
Retiree + Family	\$365.34	\$2,186.54

Above rates include dental insurance

*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.

** Rates remain status quo until contract is finalized.

In-Network Benefits

This plan is “open access” and does not require you to select a Primary Care Physician (PCP) as your source for routine care or referrals when you need specialized care. You must receive services from the network of participating providers in the **Open Access Plus Network**. An in network provider by contract, cannot charge you more than the agreed upon discounted amount for covered services. To search for a participating provider, go to www.cigna.com, select “Find a Doctor”, complete search criteria and select “Open Access Plus” for the plan then click “Search.”

Out-of-Network Benefits

The Cigna OAPIN - Gold Plan does not provide benefits for services received by providers that do not participate in the Open Access Plus Network (considered “out of network”), unless emergency care is needed when outside of the service area.

Calendar Year Deductible

There is a calendar year deductible (CYD) that needs to be met on this plan: \$500 for an individual, \$1,000 for a 2 member family and \$1,500 for a 3 or more member family. Please refer to the Wellness Incentive Buy-down Program on pages 8-10 for a voluntary one-time-per-year option to buy down your deductible. Please note the following services may be subject but not limited to the CYD: Inpatient and outpatient hospital services, ambulatory surgical services, physician charges for hospital care and surgery, consumable medical supplies and inpatient mental health services.

Calendar Year Out-of-Pocket Maximum

Once any covered member incurs in-network charges of \$1,500 for an individual, \$3,000 for a 2 member family and \$4,500 for a 3 or more member family, the plan will then provide 100% coverage thereafter for that individual or family. Charges that are applied to the out-of-pocket maximum only include CYD and coinsurance. Co-pays, pharmacy charges, fees for non-covered services and fees over the plan’s allowable are excluded.

Health Insurance: CIGNA OAPIN – Gold Plan At-A-Glance

Network	Gold – Open Access Plus In-Network (OAPIN)
Calendar Year Deductible (CYD)*	In-Network
Individual	\$500
2 Member Family	\$1,000
3 or More Member Family	\$1,500
Coinsurance (when applicable)	In-Network
Plan Reimbursement	80%
Member Responsibility	20%
Out-of-Pocket Maximum	In-Network
Individual	\$1,500
2 Member Family	\$3,000
3 or More Member Family	\$4,500
What Applies to the Out-of-Pocket Maximum	Deductible & Coinsurance (excludes Copays & Rx)
Physician Office Visits	In-Network
Primary Care Physician (PCP)	\$20 Copay
Specialists (No Referral Required)	\$30 Copay
Diagnostic Services	In-Network
Clinical Lab (Blood Work) at In-Network Facility	No Copay
X-rays at In-Network Facility	No Copay
Advanced Imaging (MRI, PET, CAT, MRA) Facility	\$75 Copay
Hospital	In-Network
Emergency Room (Waived if admitted)	\$150 Copay
Urgent Care Facility	\$50 Copay
Inpatient Hospital	20% After CYD
Outpatient Hospital	20% After CYD
Physician Services at Outpatient Hospital & Surgical Center	20% After CYD
Mental Health / Alcohol & Substance Abuse	In-Network
Inpatient	Physician office visit copay
Outpatient	20% After CYD
Prescription Drugs (Rx)	In-Network
Tier 1 – Generic	\$5 Copay
Tier 2 – Preferred Brand Name	40% of Cost, \$20 Minimum & \$50 Maximum Copay
Tier 3 – Non-Preferred Brand Name	60% of Cost, \$35 Minimum & \$85 Maximum Copay
Tier 4 – Self Administered Injectables / Specialty Drugs	\$200 Copay
Mail Order Program (90 day supply)	2x Retail Copay

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

**Please refer to the Wellness Incentive Buy-Down Program on pages 8-10.*

This benefit summary has been provided as a convenient reference. For details regarding all the plan's coverages, exclusions, and stipulations consult your certificate of coverage or contact the carrier.

Health Insurance: CIGNA OAP – Teal Plan

Cigna
 Customer Service: (877) 244-6224
 www.cigna.com or www.mycigna.com

Cigna Home Delivery Pharmacy
 Mail Order Program
 Customer Service: (800) 835-3784
 www.mycigna.com

Cigna is the City's administrator of claims for medical, dental, and pharmacy benefits. The health coverage employee/retiree costs are provided in the premium table below, followed by a brief description of the Cigna OAP - Teal Plan. A summary of the plan's schedule of benefits is on the following page. For detailed coverages, exclusions and stipulations, please refer to the summary plan description or contact Cigna.

Teal Plan

Tier of Coverage	Teamster/Non-Represented Bi-weekly	** PBA Union Bi-weekly - 2011 Rates
Employee Only	1% of Base Annual Salary / 26	\$24.00
Employee + One	\$168.14	\$165.66
Employee + Family	\$196.44	\$193.54
Dependent Age 26-30*	\$644.75/month	\$613.01/month
Tier of Coverage	Retiree (Pre 10/1/93 Hire) Monthly	Retiree (Post 10/1/93 Hire) and Surviving Spouse Monthly
Retiree Only	Up to \$109.61 based on Pension	\$644.75
Retiree + One	\$364.31	\$1,289.44
Retiree + One with Medicare A & B	\$182.16	Not applicable
Retiree + Family	\$425.63	\$2,256.51

Above rates include dental insurance

*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.

** Rates remain status quo until contract is finalized.

In-Network Benefits

Providers who contract with insurance companies agree to accept discounted rates and are referred to as either "participating" or "in network." When you receive covered services from in-network providers, you can maximize your benefits and pay less. An in-network provider, by contract, cannot charge you more than the agreed upon discounted amount for covered services. The network of participating providers that the plan utilizes is the **Open Access Plus Network**. To search for a participating provider, go to www.cigna.com, select "Find a Doctor", complete search criteria and select "Open Access Plus" for the plan then click "Search."

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 UCR. The difference between the UCR amount and the provider's higher charge is called "balance billing." **Balance billing is in addition to your deductible and coinsurance responsibility.**

Calendar Year Deductible

There is a calendar year deductible (CYD) that needs to be met on this plan: \$500 for an individual, \$1,000 for a 2 member family and \$1,500 for a 3 or more member family in-network and \$600/\$1,200/\$1,800 out-of-network, combined. Please refer to the Wellness Incentive Buy-down Program on page 9 for a voluntary one-time-per-year option to buy down your in-network deductible. Please note the following services may be subject but not limited to the CYD: Inpatient and outpatient hospital services, ambulatory surgical services, physician charges for hospital care and surgery, ambulance, laboratory and x-ray services, outpatient speech and occupation therapy, outpatient physical therapy and inpatient mental health services.

Calendar Year Out-of-Pocket Maximum

Once any covered member incurs charges of \$1,500 for an individual, \$3,000 for a 2 member family and \$4,500 for a 3 or more member family in-network and \$3,000/\$6,000/\$9,000 out-of-network or any combination of both, the plan will then provide 100% coverage thereafter for that individual or family. Charges that are applied to the out-of-pocket maximum *only* include CYD and coinsurance. Co-pays, pharmacy charges, fees for non-covered services and fees over the plan's allowable are excluded.

Health Insurance: CIGNA OAP – Teal Plan At-A-Glance

Network	Teal – Open Access Plus (OAP)	
Calendar Year Deductible (CYD)	In-Network	Out-of-Network
Individual	\$500	\$600
2 Member Family	\$1,000	\$1,200
3 or More Member Family	\$1,500	\$1,800
Coinsurance (when applicable)	In-Network	Out-of-Network*
Member Responsibility	20%	40%
Out-of-Pocket Maximum	In-Network	Out-of-Network
Individual	\$1,500	\$3,000
2 Member Family	\$3,000	\$6,000
3 or More Member Family	\$4,500	\$9,000
What Applies to the Out-of-Pocket Maximum	Deductible & Coinsurance (excludes Copays & Rx)	
Physician Office Visits	In-Network	Out-of-Network*
Primary Care Physician (PCP)	\$20 Copay	40% After CYD
Specialists (No Referral Required)	\$30 Copay	40% After CYD
Diagnostic Services	In-Network	Out-of-Network*
Clinical Lab (Blood Work) at Independent Facility	No Copay	40% After CYD
X-rays at Independent Facility	No Copay	40% After CYD
Advanced Imaging (MRI, PET, CAT, MRA) Facility	\$75 Copay	40% After CYD
Hospital	In-Network	Out-of-Network*
Emergency Room (Waived if admitted)	\$150 Copay	\$150 Copay
Urgent Care Facility	\$50 Copay	\$50 Copay
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	
Physician Services at Hospital	20% After CYD	
Mental Health / Alcohol & Substance Abuse	In-Network	Out-of-Network*
Inpatient	Physician office visit copay	40% After CYD
Outpatient		
Prescription Drugs (Rx)	In-Network	Out-of-Network*
Tier 1 – Generic	\$5 Copay	Not Covered
Tier 2 – Preferred Brand Name	40% of Cost, \$20 Minimum & \$50 Maximum	
Tier 3 – Non-Preferred Brand Name	60% of Cost, \$35 Minimum & \$85 Maximum	
Tier 4 – Self Administered Injectables / Specialty Drugs	\$200 Copay	
Mail Order Program (90 day supply)	2x Retail Copay	

*Out-Of-Network Balance Billing

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the previous page.

Wellness Incentive Program

The City of Sarasota is committed to wellness and health and continues to adopt plans to encourage employees in 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 that can be picked up in Human Resources. At that point you and your doctor can determine how many targets you have achieved. This is the number that needs to be marked on the FAX cover letter and returned to Human Resources.

Wellness Targets	
Measurement	Targets
Complete Health Risk Assessment (HRA) at Health Center. Initial blood draw and return Doctor appointment.	Completed by 11/10/2011
Weight Measurement a. Waist Circumference OR b. Body Mass Index	Men-Under 40" Women-Under 35" 24 or Less
Tobacco Use	No use detected
Blood Sugar	60-120 mg/dl
Triglycerides	150 mg/dl or less
Blood Pressure	Systolic-120 or less Diastolic-80 or less
Total Cholesterol	199 mg/dl or less

Members may achieve any or all targets. The incentive is calculated on a **maximum of five 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.

You will have the option of buying down your annual deductible or reducing your payroll deduction. You will be asked to choose which option you prefer and this option will be effective January 1, 2012. If you fail to elect an option, your incentive points will be applied towards your annual deductible.

Wellness Results: How it works

All employees and retirees and one covered dependent 19 years or older (for a maximum of two per covered family) that elect to participate in the City's voluntary Wellness Incentive Program, must visit their Primary Care Physician with the 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.

If you are completing this through your Primary Care Physician, ask your Primary Care Physician to complete the remaining 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 Wellness Target Form is a two-sided form. The reverse side is a fax cover letter form that must be completed by your Primary Care Physician and returned via fax or **submitted to the Human Resources Department by November 10th, 2011**. **This Deadline cannot be extended so please plan ahead.**

Wellness Incentive Program *(continued)*

You will need to indicate on the form if you would like your targets applied to your payroll/pension deduction or your deductible. The information on the Fax Cover letter will be then be used to determine the number of Wellness Credits you and your dependents will receive. You will then select the Deductible buy-down option or the Premium buy-down option. If no selection is made, the points will be applied to your annual deductible. The Human Resources Department will use this information and calculate what your savings will be for either the deductible or the premium discount and this will be applied to your 2012 medical coverage. Each target is worth \$50 for the payroll buy-down or \$100 for the deductible buy-down.

The following pages will explain the difference between the deductible buy-down and the premium buy-down option. This Wellness program may be subject to changes and revision annually.

Please note: Your information or blood work results can be no more than 12 months old. If you have not had an annual physical or blood work in the past 12 months, you will need to get updated information by making an appointment with your doctor or at the Employee Health Center.

Deductible Buy-Down: How it works

Single Coverage: An employee may buy-down their deductible in \$100 increments for each health target achieved, up to a maximum of five targets. For example, if the employee meets five targets, their annual deductible will equal zero; they will have bought down their deductible by \$500. If the employee meets three targets, their annual deductible will equal \$200; they will have bought down their deductible by \$300 (\$500 annual deductible minus \$300 equals a \$200 deductible).

Employees with Covered Dependent: An employee and one additional covered dependent over the age of 19 may buy-down their deductible in \$100 increments for each health target achieved, up to a maximum of five targets. The targets achieved by the two participating members will be totaled and averaged for each family member.

For example, if the employee meets three targets and their spouse meets one target, the employee credit will equal \$300 plus the spouse's credit of \$100 for a total of \$400. The \$400 will be averaged, meaning divided by the two participating family members, with the outcome equaling the average family deductible buy-down of \$200. The annual deductible of \$500 minus the \$200 of the average family buy-down will equal a \$300 deductible applied to all family members.

Employee achieves	3 targets	=	\$300
Spouse achieves	1 target	=	<u>+ \$100</u>
	Family credit	=	\$400 (divided by 2 members)
	Average family buy-down of \$200		
			\$500 plan deductible per member
			<u>- \$200 buy-down</u>
			= \$300 deductible applied to each family member in 2012

Why buy down your deductible?

The deductible amount for each family member on the plan is \$500 per calendar year. This is the amount of money that you must pay first on medical services like outpatient procedures, surgeries, and hospitalizations. After you have paid your deductible of \$500 for these types of services, your medical coverage begins to cover these services at 80% and you pay 20%. If you know that you are going to use your medical coverage for services that have a deductible, like outpatient surgery or hospitalizations, you may want to buy-down your deductible for the calendar year of 2012. This deductible deduction does not impact your maximum out of pocket obligation.

Maximum available dollar amount of Wellness Credits is \$500

Wellness Incentive Program *(continued)*

Premium (or Payroll/Pension Deduction) Buy-Down: How it works

Single Coverage: An employee may buy-down their annual payroll deduction in \$50 increments for each health target achieved, up to a maximum of five targets. For example, if the employee meets five targets, their annual payroll deduction will be reduced by \$250 annually. If the employee meets three targets, their annual payroll deduction will be reduced by \$150 annually.

Employees with Covered Dependent: An employee and one additional covered dependent over the age of 19 may buy-down their payroll deduction in \$50 increments for each health target achieved, up to a maximum of five targets. The targets achieved by the two participating members will be totaled and that amount will be subtracted from their total annual payroll deductions for the plus one or family medical plan premiums.

For example, if the employee meets four targets and their spouse meets two target, the employee credit will equal \$200 (4 targets X \$50) plus the spouse's credit of \$100 (2 targets X \$50) for a total of \$300 reduction in payroll premium.

Employee achieves	4 targets (x \$50) =	\$200
Spouse achieves	2 target (x \$50) =	<u>+ \$100</u>
	Family credit =	\$300
	Reduction in annual premiums = \$300/year	

Gold Plan – Employee + Family Rate	\$168.71 per bi-weekly pay period <i>without Wellness Credit</i>
	\$4,386.96 = Annual Premium without Wellness Credit
	<u>- \$300.00</u> = Family Wellness credit
	\$4,086.46 ÷ 26 pay periods = \$157.17 per pay period with Wellness Credit

Why buy down your premium?

Your payroll or pension deduction is the same as your premium amount. If you want to see savings on your paycheck every payroll, you may want to choose this option. You will have savings that you see automatically every paycheck. If you predict that you are not going to use your medical coverage for services that would apply to deductible and co-insurance then you may want to buy-down your premium amount instead. Please refer to the section under “Why buy down your deduction?” to review the services that the \$500 deductible applies to.

Retirees with a Medicare subsidy or other subsidized rates, surviving spouses and Post-1993 retirees are not eligible for the premium buy-down. They may choose the deductible buy-down only.

Maximum available dollar amount of Wellness Credits is \$500

***All Wellness Target Forms must be submitted to Human Resources by November 10, 2011.
No exceptions.***

Health Insurance Programs

mycigna.com

mycigna.com is the 24-hour secure member self-service website and 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

24 Hour Help Information Hotline (800) CIGNA-24 (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 or go see a doctor? 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 health conditions to help you weigh the risks and advantages of treatment options. The call is FREE and is strictly confidential.

Healthy Rewards (800) 870-3470

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 1-800-870-3470.

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

Prescription Mail Order Drug Program (800) 835-3784

If you are prescribed certain maintenance medications, you have the opportunity to maximize your savings by participating in Cigna's prescription drug mail order program. For example, a generic prescription that costs \$10 per month or \$30 over a 3 month period from a retail pharmacy, that same prescription may be eligible for the mail order program which allows you to receive a 3 month supply of your medication, delivered to your home, for only \$20. You save one month's copay for each prescription received by the prescription mail order program. Additional information, including claim forms and mailing envelopes for the prescription mail order program, may be obtained by visiting www.mycigna.com.

Employee Health Center

Employee Health Center
237 Payne Parkway, Unit 101
Sarasota, Florida 34237

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

City of Sarasota Employee Health Center

The Employee Health Center (EHC) is available to employees enrolled in the City's medical health insurance plan. The EHC provides the care you and your family needs for all non emergency illnesses, at no cost to you for the visit. Schedule an appointment with the medical staff to learn more about the Employee Health Center.

HOURS OF OPERATION			
Monday	7 a.m. - 4 p.m. (closed Noon-1 p.m.)	Thursday	9 a.m. - 6 p.m. (closed 1- 2 p.m.)
Tuesday	9 a.m. - 6 p.m. (closed 1- 2 p.m.)	Friday	7 a.m. - 4 p.m. (closed Noon-1 p.m.)
Wednesday	7 a.m. - 4 p.m. (closed Noon-1 p.m.)		

Dental Insurance

Cigna

Customer Service: (800) 244-6224

www.cigna.com or www.mycigna.com

Cigna is the City's administrator of claims for dental coverage. The dental coverage employee costs for Dental Only (for those employees that waive medical coverage) are provided in the premium table at right, followed by a brief description of the Dental Preferred PPO Plan. 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. For employees and retirees on the medical plan, dental coverage is included.

Dental Insurance – Cigna Dental PPO Plan Dental Only - Bi-Weekly Per Pay Period Deductions

Tier of Coverage	Employee Cost
Employee Only	\$2.00
Employee + One	\$4.00
Employee + Family	\$6.00

Above premium deductions are for Employees who waive medical only. Not available for retirees.

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 **Radius Network**. To locate a provider in the PPO Network log on to www.cigna.com choose "Find a Doctor." Click "Advanced Search" fill out search criteria and click "Next." Choose "Cigna Dental PPO" and "Radius" as your network then "Search."

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 UCR. The difference between the UCR amount and the provider's higher charge is called "balance billing." **Balance billing is in addition to your deductible and coinsurance responsibility.**

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.

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.

Please note the following:

- Each member is entitled 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: Plan At-A-Glance

Network	Radius	
Calendar Year Benefit Maximum	In-Network	Out-of-Network
Per Member	\$1,500	
Calendar Year Deductible	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 Coinsurance: 80% (Deductible Waived)	Plan Coinsurance: 80% (Deductible Waived) <i>May be 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 Coinsurance: 80%	Plan Coinsurance: 80% <i>May be 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 Coinsurance: 50%	Plan Coinsurance: 50% <i>May be 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	

***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 previous page.

Vision Insurance

OptiCare

Customer Service: (877) 615-7732

www.opticare.com/group/cos

The City offers vision insurance through OptiCare. The vision insurance employee/retiree costs are provided in the premium table at 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.

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.

**Vision Insurance – OptiCare Bi-Weekly
Per Pay Period Deductions**

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

Out-of-Network Benefits

Covered members may also choose to receive services from vision providers that 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. Under the "Members" tab, click "Find a Provider." 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: Plan At-A-Glance

Services	In Network	Out of Network
Eye Exam	\$10 Copay	Plan reimburses member based on the type of service
Materials	\$20 Copay	
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	\$87.50 Retail Allowance
Contact Lenses*	In Network	Out of Network
Non-Elective (Medically Necessary)	Paid In Full After Copay	Not Covered
Elective (Fitting, Follow-up & Lenses)	\$150 Retail Allowance	Up to \$87.50 Reimbursement

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

Flexible Spending Accounts (FSAs)

FBMC / Wage Works
 Customer Service: (800) 342-8017
 Claims Fax: (866) 440-7145
www.fbmc-benefits.com

The City offers Flexible Spending Accounts (FSAs) administered through FBMC / Wage Works

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 \$5,000. This money will not be taxable income to you and can be used to offset the cost of a wide variety of eligible 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 (\$2,500 if you 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
- Wheelchairs
- X-rays

***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 (FSAs) *(continued)*

FSA Guidelines

- Any unused funds after a plan year ends and all claims have been filed cannot be returned to you nor carried forward to the next plan year.
- You can enroll in either or both FSAs during open enrollment period 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 grace period 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.

Here's How It Works

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

	With the Plan	Without the Plan
Salary	\$30,000	\$30,000
FSA Contribution	- \$1,000	- \$0
Taxable pay	\$29,000	\$30,000
Estimated Tax (22.65% = 15% + 7.65 FICA)	- \$6,568	- \$6,795
After Tax Expenses	- \$0	- \$1,000
Spendable Income	\$22,432	\$22,205
Tax Savings	\$227	

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 all claims have been filed can not be returned to you nor carried forward to the next plan year. 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: FBMC / Wage Works
PO Box 1800
Tallahassee, FL 32302-1800

Or Fax to: (866) 440-7145

Or electronically at:
www.myfbmc.com

Debit Card

New this year 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.

Life Insurance

Standard Insurance Company
Customer Service: (800) 348-3226 or
Benefit Office: (941) 951-3634

Basic Term Life Insurance

The City provides a Basic Life insurance benefit to all eligible employees at no cost. All 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.

Voluntary Life Insurance

Standard Insurance Company
Customer Service: (800) 348-3226 or
Benefit Office: (941) 951-3634

ACTIVE EMPLOYEES

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.

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 \$20,000 to a maximum of \$100,000.
- **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 Life	
Employee Age	Biweekly Rates per \$10,000
Under 30	\$0.32
30 - 39	\$0.56
40 - 44	\$1.02
45 - 49	\$1.80
50 - 54	\$2.90
55 - 59	\$4.98
60 - 64	\$5.76
65 - 69	\$9.00
70 - 74	\$15.36
75 +	\$24.54

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, however, 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 25th birthday if full time student).

Voluntary Dependent Life Insurance Premium Cost

Premium cost: \$0.96 Biweekly for \$ 5,000 Spouse and \$2,500 Dependent coverage.

Premium cost: \$2.10 Biweekly for \$10,000 Spouse and \$5,000 Dependent coverage.

Voluntary Life Insurance *(continued)*

Standard Insurance Company
Benefit Office: (941) 951-3631

RETIREES

Basic Term Life Insurance

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

Voluntary Life Insurance

Voluntary Life insurance is available if additional voluntary term life coverage with Standard Insurance Company was in force at the time of retirement. 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 - 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

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 health 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
- Substance Abuse
- Critical Incident Debriefing
- Child Care
- Elder Care
- Financial Referrals
- Credit Counseling
- Legal Referrals
- Crime Victim Advocate

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.

Legal Protection Plan

Legal Protection Plan

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. New this year ARAG is offering two plan levels. You may choose the ultimate advisor level for \$15.25 per month or the Ultimate Advisor Plus level for \$22.00 per month. Plan benefits include online resources, telephone advise and face to face consultations with the attorney, and much more. To learn more about the plans please contact ARAG Customer Service.

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

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

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 +**

Landlord / Tenant Matters

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

Real Estate Matters

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

Small Claims Court

- Small Claims Court Issues

Tax Issues

- Federal IRS Tax Audit
- Federal IRS Tax Collection

Traffic Matters

- Drivers 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

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

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. **[Note: the effective date may not be earlier than the date on which the privacy notice is printed or otherwise published].**

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 that 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.

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.

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.

Privacy Practices *(continued)*

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.*



GEHRING GROUP

11505 Fairchild Gardens Ave., Suite 202
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696; Fax: (561) 626-6970
www.gehringgroup.com