Indian River County Survey on Employee Health Clinics 2020	Responding Agency: City of Port St. Lucie
Contact: Sheila O'Sullivan - 772-226-1377 sosullivan@ircgov.com	Contact: Claudia McCaskill 772-344-4081
Purpose: We are evaluating the different types of employee clinics that various agencies have implemented to evaluate whether implementing a clinic would be beneficial and cost effective.	Please provide responses below and provide any details and comments that may assist us in evaluating clinic options.
Your Health Plan Participant Count:	Eff. 6/1/20: 978 Active; 4 Surviving Spouses; 3 Cobra's; 111 Retirees = 1096 total
HISTORY	
Are you self-insured for your health insurance?	Yes
Please provide the employer's monthly contribution towards the various health plan options.	See benefit Highlights booklet
Please provide the employee's monthly contribution toward the various health plan options.	See benefit Highlights booklet
What motivated your agency's decision to pursue a clinic? What were the main drivers?	Claims were climbing
Please list the goals you were hoping to accomplish when implementing a clinic. Employee benefit enhancement? Cost savings? Wellness program? Access to care?	Cost Savings; easy and convenient access to care; reduce absenteeism. Later we implemented a wellness program and our clinic assists with that.
How did you determine your organization was ready to implement a clinic?	We had meeting with all employees to get a sense of whether they would want a clinic. They didn't want to pay extra for it, so it became part of the premiums of the medical insurance instead of a separate cost.
IMPELEMENTATION PROCESS	
How long did it take from the decision to implement to go live?	I was not part of this process, but once the decision was made, we had to convert a house we owned into a proper clinic, including the lead walls for the x-ray machine. Purchasing of all the equipment had to take place, and finally, a bid on what provider would run the clinic was needed.
Describe the implementation process.	See above. We had a ribbon cutting ceremony with Council, clinic provider, consultant, and an open house for the employees.
What resources did you need? Did you use an outside consultant to assist you?	We did use a consultant to assist in the process. They were already familiar with other models in the country, so they were helpful.
What were the start up costs?	I do not have that information, but I was told the largest cost was the x-ray machine.
Which department oversees the clinic and how many staff are allocated in support of employee benefits and the employee clinic?	One person in our HR department oversees the clinic management, plus a boss to report to and the City Manager's has final approval not to mention the Budget director needs to know how much to budget for and if any upcoming expenses to expect.
Describe your communication plan to your members?	We send most information through email, but we also post common items on our intranet for employees to find, and information on dates, times, and locations are located in our Benefit Highlights booklet.

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What challenges did you face and what would you do differently? Describe lessons learned related to implementation?	As for the Electronic Medical Record, we believe that it is a cost of doing business and the clinic should not charge us for such and item that they have to have and use for the whole business, not just our clinic. We have not paid such fees, but clinics have tried to charge us for this. Make sure that your agent or consultant are not getting a kick back from the clinic provider. This does not make for good business if they're interest is not in your best interest. With our current vendor (in place since 2011) we initially had issues with their invoices not being correct. This went on for over a year with turnover. They were always shorting themselves. So, finally we added to the bonus provision of their contract that if they received less than a 95% score for the year, it would affect their bonus and it finally was resolved. One of the main thing we urged in our bid process is little to no turn over in staff. Patients hate the inconvenience of have to retell their history over and over, so that is one of the main reasons we stayed with a local vendor vs. a national chain which we had before and clinic staff was like a revolving door, the company was like a temp agency. One of the great things our current provider does when a patient is not satisfied with their service is to speak to them directly. Meaning, if the patient called me (passive-aggressive) to complain, I would contact the clinic and they would call the patient directly to address the issue. This eliminates the middle person and not only holds the clinic staff accountable, but the patient learns that they need to communicate if they are not satisfied for whatever reason. For example, one patient contact me and stated that the nurse talked down to her because the patient didn't have a degree. After speaking to the nurse, and having personally seen her in the past, they explained they have to explain things as simply as possible as they do not know what level of education Nevertheless, I knew exactly what she meant as having seen it first hand, but by the nurse contacting the patient, they were able to explain and repair the relationship and the patient continued to go to the clinic in the future. When we first opened the clinic, for the first year, there were a few employees who would abuse the clinic because at first we waived the use of sick time to go to the clinic, so they would go and sit in the waiting room all day just so they didn't have to go to work, but got paid. So then we took away the no use of sick time policy and didn't reinstate that until the last two years. That's an 11 year gap.
CLINIC MODEL	
When was the clinic implemented?	Summer 2007
Describe your clinic model. Number of clinic locations, number and type of clinic staff, days and hours of operations, and services provided.	**We have one building near our main City Hall. There are 3 exam rooms, and x-ray room, a lab room, waiting room, front desk, dr. office/kitchen/x-ray tech computer. We have 1.5 office assistants, 1.5 medical assistants that can do x-rays, 1 doctor, and 1.5 nurses. Days and hours are located in the benefits highlights booklet. Our clinic providor allows us to utilize 3 other facilities (also listed in the booklet). Services provided to humans 2 weeks old and up for preventive to urgent care (not a replacement for a pediatrician). Blood draws; most vaccines; most generic prescriptions available; EKG, hearing & eye exam; annual gyno and psa exams; care for chronic and acute illnesses. Workmans' Compensation care and pre-employment physical and drug screens (including FDLE for law enforcement).**
Who is/are your vendor partner(s)?	Treasure Coast Medical Associates, LLC
Who is eligible to visit the clinic and what is the number of eligibles?	Anyone on our medical plan is eligible; we also utilize the clinic for pre-employment physical and drug screens and workers' compensation cases. We pay admin fee based on number of those on medical plan (1096 listed above).

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What is the member cost for a clinic visit?	$0
How is the clinic funded and what are the annual costs?	It is funded through the premiums employees pay to be on the medical plan as well as the City covering the majority.
How are the clinic expenses verified and paid?	They come to HR for review and we pay by Visa card.
Describe any member incentives or well being strategies associated with the clinic.	Members pay no co-pay for visits, nor for any generic prescription they are prescribed that are on hand. They can use the clinic without it affecting their sick time, if the visit is for themselves. Our wellness program is tied to having blood draws at the clinic.
Please describe any innovations or programs running in the clinic that are working well.	
Please indicate if you have any plans to expand or reduce clinic services in the future.	We've been talking about it for years. Expanding the current building; purchasing another building. The problem with getting another building is that we wouldn't see a ROI for at least 2 years and because it's not on campus, employees would not prefer to go there. As to the expansion of the building, I still don't know why it has not been done, I can't get an answer to why. The building department owns the building and we pay a lease, they did offer to expand it and just increase our rent.
OUTCOMES	
How many of your members are participating in the clinic? Please express as both as a number and percent of total eligibles.	We have monthly and quarterly reports that show us utilization, however, one member may utilize the facility more than once in a month's time, so this is not a measurement we have. Utilization varies weekly. Total number of visits May 18-Apr 19 = 7,798; May 19-Apr 20 =8,026.
Please describe any metrics you have established to determine clinic outcomes.	1. Medical emergency department visits shall be no more than 2% of the total clinic patient visits each 12 month period. 2. Maintain current level (in the beginning it was to increase levels) of clinic office visits (+/- 2%) until such time that the physical location(s) change to all for large number of patients per day. 3. Achieve annual cumulative patient satisfaction score of equal to or more than 3.5 out of 5.0, on a 1-5 scale. 4. Achieve annual cumulative billing accuracy of 95% when graded and reviwed by the City.
What reporting do you receive to demonstrate outcomes?	We received monthly reports outlining: Weekly utilization vs. capacity; Demographics such as gender and age of patients seen; referrals by specialty type; urgent care treatment types; number of prescriptions dispensed internally and number of scripts written for external fill; type of visits; top 25 diagnosis; patient satisfaction surveys with comments; number of appointments cancelled, missed, or rescheduled per day.
Please describe success/outcomes that are noteworthy.	2.67 to 1 ROI; many employees have successfully been able to quit smoking with the clinic's help.
Describe employee satisfaction with the clinic. Have you conducted employee surveys related to the clinic, if so please summarize overall employee sentiments related to the clinic.	Yes, HR has conducted periodic surveys and have received 92% satisfaction rates. Some employees do not trust that their information is kept confidential, so we have worked hard to constantly reiterate that we do not receive their PHI. Others didn't like certain staff. We have had two nurses leave in the last 2 years, so we believe better staff is currently in place.
Describe how the clinic has met the initial clinic goals stated above. How have you quanitified success as it relates to your upfront goals.	We have the performance goals listed above that our agent calculates each year; we do occassional satisfaction surveys; the reports show a high utilization; the ROI is great; and our medical claims trend have shown to be steady which we know is due in part because of the clinic in place.
Is there anything you would change or do differently if you had it to do it over again?	We've learned along the way and made changes. We just need a bigger facility now.

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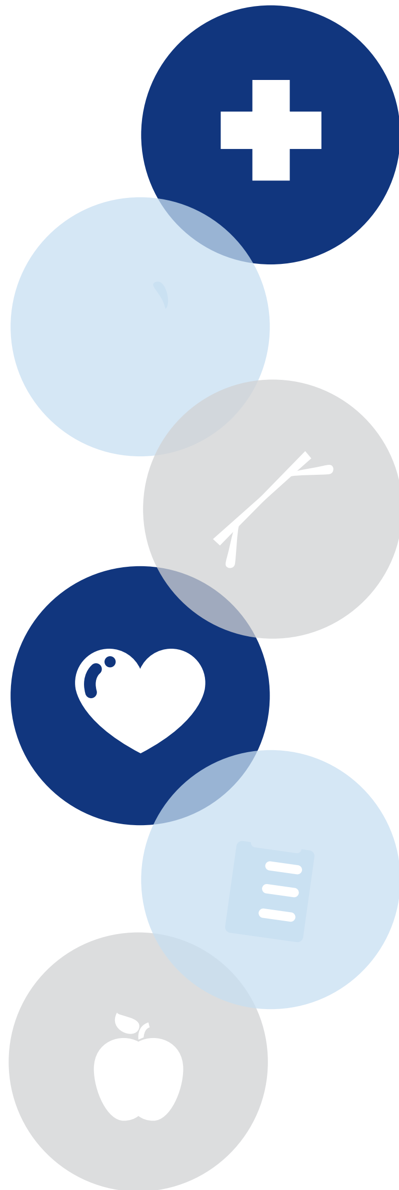
Please share any additional information that you believe would be helpful to us as we evaluate the possibility of pursing an employee clinic.	Buy-in from employees and upper management is very important. Constantly communicate with employees on everything having to do with the clinic to promote it for utilization purposes. Make sure the rooms are as sound proof as possible for privacy.
Medication	
Does the clinic provide medications through the clinic? If so, what are the member copays? If you offer medications with no copays, how was the list of “free” medications determined?	The list is based on several factors, including top ailments and most utilized meds. It must not exceed how much it would cost the City if it went through the health plan though. As needed, the clinic adjusts what meds are purchased for distribution based on whether it is still needed, if less or more is needed, and if it’s still costing less for the City.
How did you evaluate which medications to offer through the clinic? What was the main reason you offer medications through the clinic?	Prior to opening the clinic, a conversation between the clinic, agent/broker/consultant, and the City was had to determine what the top 20 issues that the City’s health plan was paying for and what the clinic could provide services for and of course space was also a factor. The list was initiated from all of these factors. Lower costs than thru the health plan.
Is the cost of medications to the employer’s plan, less than the cost through the traditional pharmacy benefit? What data was used to make this determination?	See above. The clinic compares the cost thru the plan vs. thru the site to purchase meds.
What is the annual cost to the employer’s plan of offering the medications through the clinic?	39,187.80
Do you medications expire and have to be disposed of without being dispensed to members?	Yes, on occasion this does occur. For example, flu shots, and nose sprays for allergies.

2020 | 2021 EMPLOYEE BENEFIT HIGHLIGHTS

Table of Contents



Contact Information 1
Introduction 2
Online Benefit Enrollment 2
Group Insurance Eligibility 3-4
Qualifying Events and Section 125 5
Summary of Benefits and Coverage 5
Medical Insurance 6
Other Available Plan Resources 6
Florida Blue – BlueChoice Side-By-Side Plans At-A-Glance 7
Health Reimbursement Account *(For Wellness Incentive Program Participants Only)* 8
Dental Insurance 9
Florida Combined Life BlueDental Choice Plus Plan At-A-Glance 10
Vision Insurance 11
VSP Choice Plan At-A-Glance 12
Flexible Spending Accounts 13-14
Short Term Disability 15
Long Term Disability 15
Basic Life and AD&D Insurance 15
Voluntary Life Insurance 16
Employee Assistance Program 17
Life Assistance Program 17
Supplemental Insurance 18
Supplemental Travel Insurance 18
Supplemental Pet Insurance 18
Police Officer State Death Benefit 18
Legal Insurance 19
Retiree Healthcare Coverage 19
Retirement Plans 20
Employee Health / Urgent Care Center 21
Claims, Billing & Benefit Assistance 22
Notes 22-24

This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Port St. Lucie reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

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Contact Information

Benefit	Provider	Contact
Assistant HR Director	Natalie Cabrera	Phone: (772) 344-4369 Email: ncabrera@cityofpsl.com
HR Manager	Claudia McCaskill	Phone: (772) 344-4081 Email: cmccaskill@cityofpsl.com
HR Generalist I	Alyssa Figur	Phone: (772) 879-3374 Email: afigur@cityofpsl.com
Online Benefit Enrollment	Bentek Support	(888) 5-Bentek (523-6835) www.mybentek.com/cityofpsl
Medical Insurance	Florida Blue	Customer Service: (800) 352-2583 www.floridablue.com
Prescription Drug Coverage & Mail-Order Program	Alliance Rx Walgreens Prime	Customer Service: (888) 849-7865 www.floridablue.com
Health Reimbursement Account	Chard-Snyder	Customer Service: (800) 982-7715 www.chard-snyder.com
Dental Insurance	Florida Combined Life	Customer Service: (888) 223-4892 www.floridablue.com
Vision Insurance	Vision Service Plan	Customer Service: (800) 877-7195 www.vsp.com
Flexible Spending Accounts	Chard-Snyder	Customer Service: (800) 982-7715 www.chard-snyder.com
Short & Long Term Disability Insurance	Cigna	Customer Service: (800) 362-4462 www.cigna.com
Basic Life and AD&D Insurance	Cigna	Customer Service: (800) 362-4462 www.cigna.com
Voluntary Life Insurance	Cigna	Customer Service: (800) 362-4462 www.cigna.com
Employee Assistance Program	Magellan Healthcare	Customer Service: www.MagellanHealth.com/member
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflac.com
	Metropolitan Life Insurance	Customer Service: (866) 713-1690 www.madisonplanning.com
Legal Insurance	LegalSheild	Customer Service: (800) 729-7998 www.legalshield.com
Employee Health/Urgent Care Center - Port St. Lucie	Employee Family Health Center	Customer Service: (772) 807-4430 www.cpslhealth.com Access Code:
Employee Health/Urgent Care Center - Stuart	Treasure Coast Medical Associates	Customer Service: (772) 692-8082 www.stuarturgentcare.com
Employee Health/Urgent Care Center - Okeechobee	Treasure Coast Medical Associates	Customer Service: (863) 484-8154 www.tcmahealthcare.com
Claims, Billing & Benefit Assistance	Gehring Group	Customer Service: (800) 244-3696 Email: cityofpsl@gehringgroup.com

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Introduction

The City of Port St. Lucie provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City's Handbook, Union Contract and/or the group's insurance Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If an employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources for further information.

Online Benefit Enrollment

The City provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying life events and review and make changes to Life insurance beneficiary designations.

To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/cityofpsl**
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday, during regular business hours, 8:30am - 5:00pm.

To access Employee Benefits Center online, log on to:
www.mybentek.com/cityofpsl

Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*

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Group Insurance Eligibility

The City's group insurance plan year is October 1 through September 30.

General Employee Eligibility

Employees are eligible to participate in the City's group insurance plans if they are full-time employees. Coverage will be effective the first day of the month following 60 calendar days of employment. For example: If employee is hired on April 11, effective date will be July 1. If eligible employee is reinstated (<1yr) the employee's insurance will be reinstated as of the first of the month following date of reinstatement.

Police Officer Eligibility

Police Officer's are eligible to participate in the City's group insurance plans if they are full-time employees. Coverage will be effective the first day of the month following full-time date of hire. For example: If employee is hired on April 11, effective date will be May 1.

Elected Officials Eligibility

Elected Officials are eligible to participate in the City's group insurance plans. Coverage will be effective the first day of the month following swear-in date. For example: If employee is sworn in on November 11, effective date will be December 1.

Please Note: *Newly hired employees working an average of 30 hours per week or more will be considered "full-time" for the purposes of benefit eligibility status.*

Separation of Employment

If employee separates employment from the City, insurance will continue through the end of the month in which the separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse (legally valid existing marriage as defined by Florida Law) and/or dependent child(ren) of the participant or the spouse. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 18 months old) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Age Requirements

Medical, Dental and Vision Coverage: A dependent child may be covered through the end of calendar year in which the child turns age 26.

An over-age dependent may continue to be covered through the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- 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.

Please Note: *Plan Carriers may require proof of full-time student status if over-age dependent*

Deductions Related to "Over-Age" Dependents

IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to an Over-Age (Non-Qualified) Dependent. Employees insuring Over-Age Dependents will see the insurance premium deductions post-tax and should consult their tax expert. Contact Human Resources for information and rates.

Disabled Dependents

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

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group's insurance plan; and
- The dependent has been continuously insured.

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

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Group Insurance Eligibility *(Continued)*

Please note: To enroll new dependents on the City's group insurance plan(s), maintain enrollment for current dependents, or enroll new dependents in the City's group insurance plan(s) during the open enrollment period, employee will be required to provide documentation verifying the eligibility of employee's dependents to Human Resources.

Dependent Relationship	Document(s) employee will need to provide to verify eligibility
Spouse	• Official Marriage Certificate **AND** • Certificate of Dependent Eligibility signed by employee
Child(ren) Under Age 26	• State issued birth certificate(s) **OR** legal guardianship court documents, listing employee or spouse as parent/legal guardian **AND** • Certificate of Dependent Eligibility signed by employee
Stepchild(ren) Under Age 26	• **AND** the appropriate dependent child documentation listed above
Child(ren) under Legal Guardianship or Custody Under Age 26	• **AND** court documents of the legal guardianship **OR** legal custody
Child(ren) under Foster Care Under Age 18	• **AND** court documents of legal guardianship
Child(ren) adopted or in the process of adoption Under Age 26	• **AND** court documents of the legal adoption showing relationship to and placement in the employee's house OR adoption certificate issued through the courts
Grandchild(ren) OR other children not related	• **AND** State issued Birth Certificate of child(ren) stating child was born to an insured dependent child of employee or spouse **OR** • Legal Guardianship/Custody/Foster Care Document from the courts
Child(ren) Age 26 - 30	• State issued birth certificate(s) **OR** legal guardianship court documents, listing employee or spouse as parent/legal guardian **AND** • Certificate of Dependent Eligibility signed by employee • **AND** Overage Dependent Affidavit signed by employee

All documentation must be either the original document or a notarized/certified copy of original document. Please note: Human Resources will need to view the original documents and will make copies for employee files, unless the document was uploaded through the Document Center in Bentek.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

It is the employee's responsibility to notify Human Resources when employee's dependent is no longer eligible to be covered under the plan in order to remove them and/or end dependent coverage and applicable deductions. Retro adjustments may not be able to be made. Please understand that any misstatements regarding your dependent's eligibility may result in disciplinary action up to and including termination of employment.

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Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, **Human Resources must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event or date written request for change in coverage is received by Human Resources. Newborns are effective on the date of birth. Marriage is effective the date of occurrence. Cancellations will be processed at the end of the month. In the event of death, coverage terminates the day following the death. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plans is provided as a supplement to this booklet being distributed to new hires and existing employees during the Open Enrollment Period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Human Resources
Address:	121 SW Port St. Lucie Blvd. Port St. Lucie, FL 34984
Phone:	(772) 344-4081
Email:	cmccaskill@cityofpsl.com
Website URL:	www.mybentek.com/cityofpsl

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 group certificate of coverage can be reviewed and obtained by contacting Human Resources or at www.mybentek.com/cityofpsl.

If there are any questions about the plan offerings or coverage options, please contact Human Resources at (772) 344-4081.

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Medical Insurance

The City offers medical insurance through Florida Blue to benefit-eligible employees. The costs per month for coverage are listed in the premium table(s) below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plan(s), please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Florida Blue's customer service.

Medical Insurance – Florida Blue – BlueChoice 0727 Basic Plan

Monthly Premium Cost

Tier of Coverage	City Contribution	Employee Contribution*	Retirees
Employee Only	$605.17	$52.62	$657.79
Employee + Spouse	$1,381.36	$263.11	$1,644.47
Employee + Child(ren)	$1,022.20	$194.71	$1,216.91
Employee + Family	$2,072.04	$394.67	$2,466.71

**Employee contribution rates are subject to change due to collective bargaining or, for non-bargaining unit employees, revised budgetary policies.*

Please Note: *Coverage for over-age dependents will include an additional monthly premium amount.*

Medical Insurance – Florida Blue – BlueChoice 0702 Traditional Plan

Monthly Premium Cost

Tier of Coverage	City Contribution	Employee Contribution*	Retirees
Employee Only	$649.82	$80.32	$730.14
Employee + Spouse	$1,487.68	$337.69	$1,825.37
Employee + Child(ren)	$1,100.88	$249.89	$1,350.77
Employee + Family	$2,172.00	$493.03	$2,665.03

**Employee contribution rates are subject to change due to collective bargaining or, for non-bargaining unit employees, revised budgetary policies.*

Please Note: *Coverage for over-age dependents will include an additional monthly premium amount.*

Florida Blue | Customer Service: (800) 352-2583 | www.floridablue.com

Other Available Plan Resources

Florida Blue offers all enrolled members and dependent(s) additional services and discounts through value added programs. **For more details regarding other available plan resources, please contact Florida Blue customer service at (800) 352-2583 or visit www.floridablue.com.**

Hearing Aid/Exam Reimbursement Benefit

The City provides active employees and their disabled dependent children, covered under The City's medical plan, a lifetime maximum benefit of up to $1,000 for the reimbursement of hearing aids and hearing exams. This benefit is outside the normal parameters of The City's medical plan coverage, and therefore, must go through the Human Resources department for processing. For details of this policy, please contact Human Resources for further information.

The Florida Blue Mobile App

Florida Blue's mobile website can be accessed from any smartphone or download the app from iPhone® or Android™ with just a tap! Visit the smartphone's app store and search for Florida Blue or visit http://apps.floridablue.com.

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Florida Blue – BlueChoice Side-By-Side Plans At-A-Glance

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select BlueChoice network.

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage document.*

***Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest or when having labs done in a provider's office, please confirm they are contracted with Florida Blue's BlueChoice network prior to receiving services.*

****Charges may vary based on facility of service.*

*****PAD: Per Admission Deductible*

Plan	BlueChoice 0727 Basic		BlueChoice 0702 Traditional	
Network	**BlueChoice**		**BlueChoice**	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Single	$750	$1,500	$300	$300
Family	$1,500	$3,000	$900	$900
Coinsurance				
Member Responsibility	30%	60%	10%	30%
Calendar Year Out-of-Pocket Limit				
Single	$3,000	$6,000	$1,500	$1,500
Family	$6,000	$12,000	$4,500	$4,500
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx		Deductible, Coinsurance, Copays and Rx	
Physician Services				
Primary Care Physician *(PCP)* Office Visit	$30 Copay	60% After CYD	$20 Copay	30% After CYD
Specialist Office Visit	$60 Copay	60% After CYD	$40 Copay	30% After CYD
Non-Hospital Services; Freestanding Facility				
Clinical Lab *(Bloodwork)***	$20 Copay	60% After CYD	10% Coinsurance	30% Coinsurance
X-rays at Independent Facility***	30% After CYD	60% After CYD	$40 Copay	30% After CYD
Advanced Imaging *(MRI, PET, CT)****	30% After CYD	60% After CYD	$40 Copay	30% After CYD
Outpatient Surgery in Surgical Center	30% After CYD	60% After CYD	$40 Copay	30% After CYD
Physician Services at Surgical Center	30% After CYD	60% After CYD	$35 Copay Per Provider	30% After CYD
Urgent Care *(Per Visit)*	$100 Copay	$100 Copay After CYD	$20 Copay	$20 Copay After CYD
Hospital Services				
Inpatient Hospital *(Per Admission)*	30% After CYD	60% After CYD	10% After CYD	$300 PAD**** + 30% After CYD
Outpatient Hospital *(Per Visit)*	$500 Copay	60% After CYD	10% After CYD	30% After CYD
Physician Services at Hospital	$60 Copay	$60 Copay	10% After CYD	10% After CYD
Emergency Room *(Per Visit, Copay Waived if Admitted)*	$500 Copay	$500 Copay	$50 Copay + 10% After CYD	$50 Copay + 10% After CYD
Mental Health / Alcohol & Substance Abuse				
Inpatient Hospital Services *(Per Admission)*	30% After CYD	60% After CYD	10% After CYD	10% After CYD
Outpatient Services *(Per Visit)*	$500 Copay	60% After CYD	10% After CYD	30% After CYD
Outpatient Office Visit	$60 Copay	60% After CYD	$40 Copay	30% After CYD
Prescription Drugs *(Rx)*				
Generic	$10 Retail Copay	50% Coinsurance	$10 Retail Copay	50% Coinsurance
Preferred Brand Name	$45 Retail Copay	50% Coinsurance	$30 Retail Copay	50% Coinsurance
Non-Preferred Brand Name	$75 Retail Copay	50% Coinsurance	$50 Retail Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	$20 / $90 / $150 Copay	Not Covered	$20 / $40 / $60 Copay	Not Covered

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Health Reimbursement Account *(For Wellness Incentive Program Participants Only)*

The City's Health Reimbursement Account (HRA) is administered by Chard Snyder. HRAs are only for employees who have received wellness incentives by meeting and achieving wellness targets or completing wellness activities while on the City's BlueChoice Health Plan(s) during the 10/1/20 through 9/30/21 plan year. HRA monies are funded by the City and may be used for any qualified medical, dental and vision expenses incurred.

Retain Receipts

During the year, employee should keep all receipts and documentation for prescriptions and medical, dental and vision related expenses if needed to verify a claim for Chard Snyder 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.

Check Available HRA Balance

Balance, activity and account history information is available online at www.chard-snyder.com or by calling Chard Snyder at (800) 982-7715.

Expenses Eligible for Reimbursement

Employee may request reimbursement of expenses for employee or covered dependent(s). Eligible expenses must be necessary for the diagnosis, treatment, cure, mitigation or prevention of a specific medical condition. Cosmetic expenses are not eligible for reimbursement. Reimbursement checks will be issued to employee throughout the year for incurred expenses up to the maximum annual benefit amount. Employee has the option to have reimbursement checks direct deposited into employee's bank account. For more information regarding eligible expenses, visit Chard Snyder online at www.chard-snyder.com.

File a Claim

Debit Card

Each eligible employee will be provided a prepaid benefit card to use for payment of out-of-pocket medical expenses. This may prevent the employee from having to pay an expense first and then seek reimbursement. However, employee may be required to submit documentation of any expenses that do not match a copay associated with a specific service under the medical plan.

Paper Claim

Employee may submit claim forms to Chard Snyder and must include a copy of carrier's Explanation of Benefits or receipts for eligible medical services received. Claim forms can be submitted by mail, email or fax.

Claims Mailing Address
6867 Cintas Blvd., Mason, OH 45040

Chard Snyder | Customer Service: (800) 982-7715 | www.chard-snyder.com
Email: askpenny@chard-snyder.com | Fax: (888) 245-8452

Health Reimbursement Account (HRA)

- ✓ **Employer** Funded Account
- ✓ Enrollment is automatic if enrolled in medical plan
- ✓ Funds used for eligible medical, dental, and vision expenses for employees and their dependents who are enrolled in medical plan
- ✓ Unused funds accumulate and roll over year to year

Flexible Spending Accounts (FSA)

- ✓ **Employee** Funded Accounts
- ✓ Employees must enroll annually
- ✓ Funds used for eligible medical, dental, vision & dependent care expenses for employees and their qualified dependents
- ✓ Unused funds will be forfeited at the end of the plan year (once the filing deadlines have expired)

Please Note: If an employee has the HRA and also elects an FSA, FSA monies will be used first since it is employee funded.

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Dental Insurance

Florida Combined Life BlueDental Choice Plus Plan

The City offers dental insurance through Florida Combined Life to benefit-eligible employees. The costs per month for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Florida Combined Life's customer service.

Dental Insurance – Florida Combined Life BlueDental Choice Plus Plan

Monthly Premium Cost

Tier of Coverage	City Contribution	Employee Contribution*	Retirees
Employee Only	$29.10	$2.55	$31.65
Employee + Spouse	$102.10	$20.90	$123.00
Employee + Child(ren)	$57.80	$11.85	$69.65
Employee + Family	$102.95	$21.10	$124.05

**Employee contribution rates are subject to change due to collective bargaining or, for non-bargaining unit employees, revised budgetary policies.*

Please Note: *Coverage for over-age dependents, will include an additional monthly premium amount.*

In-Network Benefits

The BlueDental Choice Plus plan provides benefits for services received from in-network and out-of-network providers. It is also an open access plan which allows for services to be received from any dental provider without selecting a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Florida Combined Life BlueDental Choice Plus Network. These participating dental providers have contractually agreed to accept Florida Combined Life's contracted fee or "allowed amount." This fee is the maximum amount a Florida Combined Life dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Florida Combined Life BlueDental Choice Plus provider. Florida Combined Life reimburses out-of-network services based on what it determines is the Usual, Customary, and Reasonable (UCR) charge. The UCR is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between Florida Combined Life's UCR and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The BlueDental Choice Plus plan requires a $50 individual or a $100 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the BlueDental Choice Plus plan will pay for each covered member is $1,500. All services, including preventive services, accumulate towards benefit maximum. Once the plan's benefit maximum is met the member will be responsible for future charges until next calendar year.

Claims Mailing Address | Dental Claims Administrator
PO Box 1047, Elk Grove Village, IL 60009-1047

Florida Combined Life
Customer Service: (888) 223-4892 | www.floridablue.com

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Florida Combined Life BlueDental Choice Plus Plan At-A-Glance

Network	BlueDental Choice Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	$50
Per Family	$100	$100
Waived for Class I Services?	Yes	Yes
Calendar Year Benefit Maximum		
Per Member	$1,500	$1,500
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(1 Every 6 Months)* Routine Cleanings *(1 Every 6 Months)* Bitewing X-rays *(1 Every 6 Months)* Complete X-rays *(1Set Every 3 Years)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Class II Services: Basic Restorative		
Fillings *(Amalgam & Composite)* Simple Extractions Endodontics *(Root Canal Therapy)* Periodontal Services Anesthesia *(In Connection with Covered Dental Charge)*	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Class III Services: Major Restorative Care		
Crowns Bridges Dentures	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	$1,000
Benefit	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select Dental - BlueDental Choice & Choice Plus (PPO) network.

Plan References

Out-Of-Network Balance Billing: *For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the out-of-network benefits section on the previous page.*

Important Notes

- *Each covered family member may receive up to two (2) routine cleanings per calendar year under the preventive benefit. Cleanings must be six (6) months apart.*
- *For any dental work expected to cost $500 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply for certain benefits.*
- *Benefit frequency limitations may apply to certain services.*

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Vision Insurance

VSP Choice Plan

The City offers vision insurance through Vision Service Plan (VSP) to benefit-eligible employees. The costs per month for coverage are listed in the premium table below and a brief summary of the benefits is provided on the following page. For detailed information about the vision plan, please refer to the carrier's summary plan document or contact VSP's customer service.

Vision Insurance – VSP Choice Plan
Monthly Premium Cost

Tier of Coverage	City Contribution	Employee Contribution*	Retirees
Employee Only	$5.82	$0.51	$6.33
Employee + Spouse	$20.42	$4.18	$24.60
Employee + Child(ren)	$11.56	$2.37	$13.93
Employee + Family	$20.59	$4.22	$24.81

**Employee contribution rates are subject to change due to collective bargaining or, for non-bargaining unit employees, revised budgetary policies.*

***Please Note:** Coverage for over-age dependents will include an additional monthly premium amount.*

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered employee and dependent(s) can select any network provider who participates in the VSP Choice network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may also choose to receive services from vision providers who do not participate in the VSP Choice network. When going out of network, the provider will require payment at the time of appointment. VSP will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

VSP | Customer Service: (800) 877-7195 | www.vsp.com

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VSP Choice Plan At-A-Glance

Network	VSP Choice	
Services	**In-Network**	**Out-of-Network**
Eye Exam	No Charge	Up to $45 Reimbursement
Frequency of Services		
Examination	12 Months	12 Months
Lenses	12 Months	12 Months
Frames	12 Months	12 Months
Contact Lenses	12 Months	12 Months
Lenses		
Single	No Charge	Up to $30 Reimbursement
Bifocal	No Charge	Up to $50 Reimbursement
Trifocal	No Charge	Up to $65 Reimbursement
Frames		
Allowance	Up to $115 Allowance; Up to $135 Allowance for Featured Frame Brands	Up to $70 Reimbursement
Contact Lenses*		
Non-Elective *(Medically Necessary)*	No Charge	Up to $210 Reimbursement
Elective *(Fitting, Follow-up & Lenses)*	Up to $115 Allowance After Maximum $60 Copay	Up to $105 Reimbursement
LASIK		
Discount Programs	Contact VSP for Program Details	Not Available

Locate a Provider

To search for a participating provider, contact VSP's customer service or visit www.vsp.com. When completing the necessary search criteria, select VSP Choice network.

Plan References

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

Important Notes

Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.

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Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through Chard-Snyder. The FSA plan year is from October 1, 2020 through September 30, 2021.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from the employee's paycheck and deposited into the FSA. During the year, the employee has access to the account for reimbursement of certain expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are two types of FSAs:

Health Care FSA

This account allows participant to set aside up to an annual maximum of $2,750. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- 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 eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care Reimbursement Account, reimbursement is only up to the amount that has been deducted from the participant s paycheck for the Dependent Care Reimbursement Account.

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

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

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Flexible Spending Accounts *(Continued)*

FSA Guidelines

- The Health Care and Dependent Care FSA allow a 2.5 month grace period at the end of the plan year. The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- The Health Care FSA has a run out period at the end of the plan year (90 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year and/or grace period.
- When a plan year and grace period ends and all claims have been filed all unused funds will be forfeited and not returned.
- Employee can enroll in either or both of the FSAs only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail, email or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants enrolled in the HRA, will use the same debit card for both the HRA and FSA eligible expenses. Newly enrolled FSA participants will automatically receive a debit card for payment of eligible expenses. **If an employee has the HRA and also elects an FSA, FSA monies will be used first since it is employee funded.** With the card, most qualified services and products can be paid 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.

Chard-Snyder may request supporting documentations for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to Chard-Snyder. This card will not expire at the end of the benefit year. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $83.33 based on a monthly 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 a Health Care FSA	Without a Health Care FSA
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**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year.* ***This rule is known as "use it or lose it."***

Claims Mailing Address
6867 Cintas Blvd., Mason, OH 45040

Chard Snyder
Customer Service: (800) 982-7715 | www.chard-snyder.com
Email: askpenny@chard-snyder.com | Fax: (888) 245-8452

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Short Term Disability

The City provides Short Term Disability (STD) insurance at no cost to all eligible employees through Cigna. The STD benefit pays employee a percentage of the weekly earnings if employee becomes disabled due to an illness or non-work related injury.

Short Term Disability (STD) Benefits

- STD provides a benefit of 60% of employee's weekly earnings up to a benefit maximum of $1,500 per week.
- Employee must be disabled for 29 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 30th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 26 weeks.
- Employee deemed unable to return to work after the STD 26 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefit may be reduced by other income.
- Disability benefits are taxable.

Cigna | Customer Service: (800) 362-4462 | www.cigna.com

Long Term Disability

The City provides Long Term Disability (LTD) insurance at no cost to all eligible employees through Cigna. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or non-work related injury.

Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $5,000 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will commence on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.

Cigna | Customer Service: (800) 362-4462 | www.cigna.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance for all eligible employees at no cost, through Cigna. Eligible employees will receive a benefit amount of $50,000.

Accidental Death & Dismemberment Insurance

Also, at no cost to employee, the City provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- Reduces to 45% of the benefit amount at age 70
- Reduces to 35% of the benefit amount at age 75
- Reduces to 25% of the benefit amount at age 80

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek by visiting www.mybentek.com/cityofpsl.

Cigna | Customer Service: (800) 362-4462 | www.cigna.com

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Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee may elect to purchase additional Life insurance on a voluntary basis through Cigna. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life insurance offers coverage for employee, spouse or child(ren) at different benefit levels.

New Hires may 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 $200,000**.

- Units may be purchased in increments of $10,000 to a maximum of $500,000, up to five (5) times the employee's annual salary.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 45% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75
  - Reduces to 25% of the benefit amount at age 80
- Group coverage cancels at retirement or if employment with the City is terminated.

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Spouse Life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $50,000**.

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Units may be purchased in increments of $5,000, to a maximum of $250,000 not to exceed 100% of the employee's Voluntary Life coverage amount.
- Benefit amounts are subject to the following age reduction schedule, reducing as the employee ages:
  - Reduces to 45% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75
  - Reduces to 25% of the benefit amount at age 80

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- For eligible unmarried children, from date of birth up to age 26.
- Units may be purchased in increments of $5,000 to a maximum of $10,000.
- Rates are $0.46 per month for $5,000 or $0.92 per month for $10,000; regardless of number of dependent child(ren) enrolled.

Voluntary Life Rate Table

Rate Per $1,000 of Benefit

Age Bracket *(Based On Employee Age)*	Employee/Spouse *(Rate Per $1,000 of Benefit)*
0-29	$0.075
30-34	$0.085
35-39	$0.130
40-44	$0.150
45-49	$0.230
50-54	$0.360
55-59	$0.670
60-64	$1.020
65-69	$1.970
70-74	$3.190
75-79	$5.150
80+	$5.150

It is the employee's responsibility to notify Human Resources when employee's dependent is no longer eligible to be covered under the plan in order to remove them and/or end dependent coverage and applicable deductions. No retro adjustments will be made.

Cigna | Customer Service: (800) 362-4462 | www.cigna.com

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Employee Assistance Program

As part of the employee's benefits package the City provides a comprehensive Employee Assistance Program (EAP) available to employee and each family member through Magellan Healthcare. Magellan Healthcare offers access to licensed mental health professionals through a confidential program protected by state and federal laws. The EAP program is available to assist in understanding problems that affect employee or household member, locate the best professional help for a particular concern, and decide upon a plan of action. All EAP counselors are professionally trained, certified and licensed. Master-level counselors are available 24 hours a day, seven (7) days a week. The EAP also includes eight (8) free face-to-face sessions, per member, per issue.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employee and family member(s) free and convenient access to a range of confidential and professional services to help address a variety of problems that can negatively affect well-being such as:

- ✓ Anxiety
- ✓ Legal and Financial Concerns
- ✓ Depression
- ✓ Life Improvement
- ✓ Family and/or Marriage Issues
- ✓ Stress
- ✓ Grief and Bereavement
- ✓ Substance Abuse
- ✓ Legal & Financial Consultation
- ✓ Eight (8) face-to-face counseling sessions

The City recognizes that employees' personal responsibilities may, at times, spill over into the workplace. To help ensure employee is able to address these concerns with minimal disruption, the program provides employee and family members assistance for a variety of concerns – including child care, elder care, daily-living issues, and other issues that may effect employee or family member(s).

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), they 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/manager will not, however, receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Magellan Healthcare
Customer Service: [redacted] | www.MagellanHealth.com/member

Life Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Life Assistance Program (LAP) through Cigna. LAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. LAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. LAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is a Life Assistance Program (LAP)?

A Life Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) face-to-face visits with a specialist, per person, per issue, per year, telephonic consultation, online material/tools and webinars. LAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Legal Resources
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Pet Care

Are Services Confidential?

Yes. Receipt of LAP services are completely confidential. If, however, participation in the LAP 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/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Cigna's Life Assistance Program
Customer Service: [redacted] | www.cignalap.com

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Supplemental Insurance

Aflac

Aflac offers a variety of supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction on a pre-tax basis. Aflac pays money directly to employee, regardless of what other insurance plans employee may have. To learn more about these Aflac plans and/or to schedule a personal appointment, contact the local Aflac agent. Details regarding available Aflac plans and services are also available online at www.aflac.com.

Available plans include:

- **Group Critical Illness with Cancer Plan (GI)** – Provides a flat benefit amount of $30,000 for employee or $15,000 for employee's spouse when needed to help with treatment costs for covered critical illness and cancer.
- **Group Hospital Indemnity Plan (GI)** – Provides cash benefits for illness or injury resulting in hospitalization, daily ICU confinement, in-patient and out-patient services, and wellness.
- **Accident Plan** – Pays cash benefits for expenses resulting from injuries on or off the job, including: hospitalization, office and ER visits, physical therapy, and other medical expenses.
- **Dental Plan** – Provides benefits for checkups, cleanings, x-rays, fillings, crowns, cosmetic, orthodontic services and more.
- **Vision Plan** – Covers eye exams and reimbursement for contacts or glasses.

Aflac | Customer Service: (800) 992-3522 | www.aflac.com
Agent: Margaret Pearson | Phone: (561) 881-1964
Email: margaret_pearson@us.aflac.com

MetLife

MetLife Insurance is offered through Madison Planning Group and may be purchased separately on a voluntary basis. It is available for employee, spouse, children, and grandchildren with premiums paid by payroll deduction after tax. This permanent life insurance policy can be purchased as a supplement to the basic group life insurance offered through the City. The policies are portable, even if you change jobs or retire, as long as you pay the necessary premium you may continue the policy. To learn more about the MetLife Insurance Plan or to schedule an appointment, contact Janet or Tara Froyen.

Metropolitan Life Insurance
Agent: Janet Froyen | Phone: (561) 704-4378
Email: jfroyen@madisonplanning.com
Agent: Tara Froyen | Phone: (561) 602-2827
Email: tfroyen@madisonplanning.com
www.madisonplanning.com

Supplemental Travel Insurance

Cigna Secure Travel

The City provides members that are enrolled in the Voluntary Group Accidental Dealth and Dismemberment (AD&D) plan, additional travel programs to help with unforeseen issues while traveling at no cost, through Cigna.

- ✓ 24 Hour Toll Free Emergency Service Line
- ✓ Emergency Medical Assistance
- ✓ Emergency Personal Services
- ✓ Pre-Trip Information
- ✓ Emergency Documentation Replacement

Cigna | Customer Service: (888) 226-4567

Supplemental Pet Insurance

ASPCA

The City provides the employees the opportunity to purchase pet insurance benefits on a voluntary basis directly through ASPCA. Coverage includes exam fees, diagnostics and treatments for:

Dogs and cats:

- ✓ Accidents
- ✓ Illness
- ✓ Cancer
- ✓ Hereditary Conditions
- ✓ Behavioral Issues
- ✓ Dental Disease

Pets must be older than 8 weeks to enroll and a 14 day waiting period will apply at enrollment. To learn more and sign up visit the ASPCA website or call customer service.

ASPCA | Customer Service: (877) 343-5314
www.aspcapetinsurance.com/CityofPSL | Priority Code: EB20CityofPSL

Police Officer State Death Benefit

Please refer to Florida State Statue 112.19 for qualifying benefits and amounts.

Risk Management | Customer Service: (772) 871-7371

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Legal Insurance

LegalShield

The City offers legal insurance through LegalShield on a voluntary basis via payroll deduction. The LegalShield plan gives members access to professional legal counsel not only for traditional legal problems, but for everyday events such as buying a house or a car, creating a will, handling a problem with an insurance company, dealing with identity theft and other instances in which legal review should be considered.

To learn more about the types of legal plans available, including Identity Theft Shield, contact the City's LegalShield Representative. Employee can also contact LegalShield's customer service at (800) 729-7998 for assistance.

IDShield

LegalShield also offers a voluntary pre-paid identity theft protection program, IDShield. IDShield offers comprehensive privacy and security monitoring. This plan will give employee and spouse access to their credit report, plus daily monitoring of credit report. If victim of identity theft, this membership will provide an investigator to help with the restoration process. This includes contacting the State DMV, the Medical Information Bureau, all 3 Credit Repositories, Financial Institutions, the Social Security Administration, and even Criminal Records. To learn more about the benefits of this plan, contact Rebecca Smith by using the contact information provided below.

Legal Insurance
Monthly Premium Cost

	LegalShield	IDShield	LegalShield & IDShield
Member	$14.95	$8.95	$23.90
Family	$14.95	$18.95	$29.90

LegalShield | www.legalshield.com
Agent: Rebecca Smith | Office: (800) 729-7998 | Cell: (904) 237-1070
Fax: (904) 239-5467 | www.8007297998.com

Retiree Healthcare Coverage

Benefit-eligible employees participating in the City's group insurance plan(s) at the time of retirement shall be afforded the option to continue coverage as a Retiree. The retiree contribution rate is established at 100% of the determined costs for the class of coverage elected, and is assessed annually for rate adjustments each October 1. The City will not pay the costs, or a portion thereof, of any such continuation of coverage for its retirees and eligible dependent(s).

Employees Hired Before 7/12/10:

A "Retiree" is defined as an employee who voluntarily withdraws from one's position and has satisfied at least one of the following conditions:

- Completed at least five (5) years of full-time service
- Reached the age of 55
- Otherwise qualifies as a retiree under the City's Code of Ordinances or Section 112.0801(2), Florida Statutes

Employees Hired On or After 7/12/10:

A "Retiree" is defined as an employee who voluntarily withdraws from one's position and has satisfied at least one of the following conditions:

- Employee's combined attained age in whole years and Credited Service in whole years equals at least 75 (i.e., The Rule of 75) with a minimum of ten (10) years of full-time service and has reached the age of 55
- Otherwise qualifies as a retiree under the City's Code of Ordinances or Section 112.0801(2), Florida Statutes

The Retiree and any eligible dependent(s) may continue participation under the Plan effective the first day of the subsequent month following the employee's separation of service. The benefits continued under retiree coverage include the same health, prescription, vision and dental coverage the employee received as an active participant in the Plan. Retiree who continues medical coverage may also continue to participate in the City's Group Life Insurance policy for the retiree only, by making the applicable monthly contribution.

For further information regarding benefits at retirement, please contact Claudia McCaskill in Human Resources.

Retiree Healthcare Subsidy

Employees hired on or before 10/25/10, who meet the criteria, may be eligible for a Retiree Healthcare Subsidy. For details of this policy, please contact Human Resources.

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Retirement Plans

General Employees

ICMA-RC 401(a) Defined Contribution Pension Plan
Customer Service: (800) 669-7400 | www.icmarc.org

The City contributes an amount equal to 11.4% of an eligible employee's bi-weekly earnings into the ICMA-RC 401(a) Defined Contribution Plan. Employees are required to make a contribution of one percent (1%) of their gross taxable wages to the ICMA-RC 401(a) and is only mandatory for FOPE and OPEIU employees at this time. The Plan has a 5-years of eligible service or age 55 vesting requirement. There are no loan provisions. Employee becomes eligible on the first month following 60 calendar days of full-time employment.

Please Note: *Exempt Employee may choose to have their City contribution distributed into the 457 Deferred Compensation Plan.*

ICMA-RC 457 Deferred Compensation Plan
Customer Service: (800) 669-7400 | www.icmarc.org

Full and part-time employees may choose to contribute their own dollars into the ICMA-RC 457 Deferred Compensation Plan. IRS regulates the maximum amount of deferral allowed annually in the 457 plan. A participant may not exceed that annual maximum amount of deferral. A loan option is available for this plan. Employee becomes eligible on date of hire.

ICMA-RC Roth IRA Plan
Customer Service: (800) 669-7400 | www.icmarc.org

This plan allows both full and part-time employees the ability to make after-tax contributions to the Roth IRA through payroll deduction. Participant may take tax-free withdrawals of their contributions or earnings at anytime from the Roth IRA under certain conditions, first time home purchases, higher education expenses, un-reimbursed medical expenses or disability, etc. IRS regulates the maximum amount of annual contributions. Employees become eligible on date of hire.

Police Officers

Municipal Police Officers Retirement Trust Fund

Provided under Florida State Statue 185. The plan has a "5-years + 1 day of eligible service" vesting requirement. The plan offers an early retirement option at age 50 with 10 years or more of service. Normal retirement age is 52 with 25 years of service, or age 55 with 10 years of service. Police Officers shall contribute 9% of pre-taxed gross earnings. Employee becomes eligible on date of hire.

ICMA-RC 457 Deferred Compensation Plan
Customer Service: (800) 669-7400 | www.icmarc.org

Employee may choose to contribute their own dollars into the ICMA-RC 457 Deferred Compensation Plan. IRS regulates the maximum amount of deferral allowed annually in the 457 plan. A participant may not exceed the annual maximum amount of deferral. A loan option is available for this plan. Employee becomes eligible on date of hire.

ICMA-RC Roth IRA Plan
Customer Service: (800) 669-7400 | www.icmarc.org

This plan allows both full and part-time employees the ability to make after-tax contributions to the Roth IRA through payroll deduction. Participant may take tax-free withdrawals of their contributions or earnings at any time, from the Roth IRA under certain conditions, first time home purchases, higher education expenses, un-reimbursed medical expenses or disability, etc. IRS regulates the maximum amount of annual contributions. Employee becomes eligible on date of hire.

Elected Officials

Florida Retirement System (FRS)
www.myfrs.com

City Council members may participate in the Florida Retirement System (FRS) under the Elected Officers Class. The participant must make application for either the FRS Pension Plan or the FRS Investment Plan. There are different vesting requirements and distribution requirements for each of the plans. The required contribution is determined by the State Legislation annually for each class.

For additional information, please contact:
Sandy Steele | Phone: (772) 344-4070 | Email: ssteele@cityofpsl.com
Jason Suskey | Phone: (772) 344-4223 | Email: jsuskey@cityofpsl.com

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Employee Health / Urgent Care Center

Participants in the City's medical insurance plan may utilize any of the following locations for primary and urgent care medical services (all of which are operated by Treasure Coast Medical Associates):

Employee Family Health Center (West of City Hall)
2266 SW Best Street, Port St. Lucie, FL 34984 | Phone: (772) 807-4430
Fax: (772) 873-6352| www.cpslhealth.com | Access Code: [redacted]
Email: cpslclinic@tcmahealthcare.com

Hours of Operation

Day	Hours
Monday	8:00 am – 7:00 pm
Tuesday	8:00 am – 7:00 pm
Wednesday	8:00 am – 5:00 pm
Thursday	8:00 am – 7:00 pm
Friday	8:00 am – 7:00 pm
Saturday	10:00 am – 2:00 pm
Sunday	Closed

The Best Street location uses the 8am - 9am hour for blood draws only; calls are answered as of 9am.

The answering service will answer calls while the office is closed.

The Clinic will be closed on the following holidays: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day.

Treasure Coast Medical Associates (Okeechobee Urgent Care Location)
305-B NE Park Street, Okeechobee, FL 34972 | Phone: (863) 484-8154
Fax: (863) 484-8132 | www.tcmahealthcare.com
Email: stuart@tcmahealthcare.com

Hours of Operation

Day	Hours
Monday	8:00 am – 7:00 pm
Tuesday	8:00 am – 7:00 pm
Wednesday	8:00 am – 7:00 pm
Thursday	8:00 am – 7:00 pm
Friday	8:00 am – 7:00 pm
Saturday	8:00 am – 3:00 pm
Sunday	9:00 am – 3:00 pm

Treasure Coast Medical Associates (Stuart Urgent Care Location)
3405 NW Federal Highway, Jensen Beach, FL 34957 | Phone: (772) 692-8082
Fax: (772) 232-9383 | www.stuarturgentcare.com
Email: stuart@tcmahealthcare.com

Hours of Operation

Day	Hours
Monday	8:30 am – 7:00 pm
Tuesday	8:30 am – 7:00 pm
Wednesday	8:30 am – 7:00 pm
Thursday	8:30 am – 7:00 pm
Friday	8:30 am – 7:00 pm
Saturday	8:30 am – 3:00 pm
Sunday	9:00 am – 3:00 pm

Highland Urgent Care
7195 S George Blvd., Sebring, FL 33875 | Phone: (863) 451-5860
www.highlandurgentcare.com
Email: highlands@tcmahealthcare.com

Hours of Operation

Day	Hours
Monday	8:00 am – 7:00 pm
Tuesday	8:00 am – 7:00 pm
Wednesday	8:00 am – 7:00 pm
Thursday	8:00 am – 7:00 pm
Friday	8:00 am – 7:00 pm
Saturday	8:00 am – 3:00 pm
Sunday	9:00 am – 3:00 pm

Services Provided

Treasure Coast Medical Associates (TCMA) will see patients two months of age and older at all locations; however their services should not be used as a replacement for a primary pediatrician. In addition to primary care services, TCMA will provide urgent care services at all locations. Walk-ins are welcome, but patients with appointments will be given preference (except in cases of emergency).

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Q&A

Claims, Billing & Benefit Assistance

If employees have questions on claims, receive bills from providers which they do not understand or would like general information on any of the employee benefits provided, please contact the Gehring Group Service Team.

The Gehring Group Service Team works directly with the City and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember this is in addition to the City's Human Resources and is not replacing assistance employee may need from Human Resources.

Employee may contact a claims specialist by:

1. Email: cityofpsl@gehringgroup.com

Please include your name, contact information and a brief description of the issue. A Gehring Group Claims Specialist will respond via email or phone call to gather additional information.

OR

2. Call: (800) 244-3696

When calling, please identify yourself as an employee of the City of Port St. Lucie and ask to speak to a Claims Specialist or another member of the City's designated team to assist with questions or concerns.

Office hours are Monday through Friday, 8:30am – 5:00pm. If calling after office hours, please leave a message indicating you are a City employee who would like to speak with a Claims Specialist. Please leave full name, contact information and a brief message and a Claims Specialist will be in contact with you the following business day.

At the Gehring Group, our goal is to be your advocate and ensure issues are resolved as quickly as possible.

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

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Palm Beach Gardens, Florida 33410
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www.gehringgroup.com

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