THE CITY OF DAYTONA BEACH
OFFICE OF THE PURCHASING AGENT

Post Office Box 2451
Daytona Beach, Florida 32115-2451

Phone (386) 671-8080
Fax (386) 671-8085

ADDENDUM NO. 2

DATE: May 12, 2020

PROJECT: RFP 20464
EMPLOYEE BENEFITS INSURANCE CONSULTING SERVICES

OPENING DATE: June 2, 2020

This addendum is hereby incorporated into the RFP Documents for the project referenced above. The following items are clarifications, corrections, additions, deletions and/or revisions to and shall take precedence over the original documents. Additions are indicated by underlining, deletions are indicated by ~~strikethrough.~~

1. Answers to Proposer's written questions:

   Q1: a) Is the medical insurance currently full-insured, level-funded, or self-funded? b) If fully-insured, would a level or self-funded arrangement be considered?
   A1: a) fully insured b) No

   Q2: What is the carrier/network for medical, dental, life, and disability?
   A2: Medical: Florida Health Plan; Dental-The Standard; Life & AD&D US Able

   Q3: For medical, what has been the average enrollment over the last 12 months in each tier (employee only, employee + spouse, employee + child(ren), employee + family)?

A3: HMO	Triple-Option	HDHP HSA
single: 260	single: 106	single: 94
ee+spouse: 48	ee+spouse: 39	ee+spouse: 11
ee+children: 42	ee+children: 20	ee+children: 7
family: 83	family: 69	family: 20

   Q4: What is the current benefit administration system and how was it accessed?
   A4: PlanSource, through contract they have with Brown & Brown

Q5: Does this RFP/consulting service fee include retirement benefits?
A5: No

Q6: What has been the average annual hours billed under the consulting fee for the last 3 years?
A6: approximately 260 hours annually

Q7: Will the contract allow the chosen agency to receive commissions from carriers on fully-insured lines in addition to the hourly consulting fee?
A7: No

Q8: Would performance-based contracts where compensation is derived from meeting mutually set goals be entertained?
A8: No.

Q9: Would performance-based contracts where compensation is derived from meeting mutually set goals be entertained?
A9: No

Q10: Who is the current Consultant and for how long have they serviced City of Daytona Beach?
A10: Brown & Brown of Florida

Q11: What is their annual compensation from all sources; including, fees, commissions, over-rides or bonuses?
A11: $150 per hour

Q12: Will the City of Daytona Beach accept a proposal based on fee rather than hourly rate?
A12: No

Q13: Does the City have a wellness initiative? If so, please describe.
A13: As part of our health insurance plan with Florida Healthcare Plans we have a wellness rider that gives employees and their dependents 18+ years old access to various participating gyms in the area.

Q14: Does the City have an onsite clinic? If so, what services are provided?
A14: No. We have an onsite occupational nurse that is more of a facilitator of care for workers' compensation than someone who treats.

Q15: Please provide a current list of carriers/vendors and number of enrolled in each plan?
A15: already provided

Q16: What is the total number of eligible employees at the City? Total enrolled in medical? A16: Approximately 800 employees. Approximately 1,200 total including dependents

Q17: Are retiree services included? If so, please clarify services and number involved.
A17: Retirees can opt to remain on our health and dental at retirement. We have approximately 35 retirees still on health plan. With their dependents, it adds another 50 participants to the plan.

Q18: What collective bargaining agreements are in place for how many in your population?
A18: We have 4 different collective bargaining agreements. Coastal FL PBA for police sergeants and officers, Florida State Lodge Fraternal Order of Police for Police Lieutenants, IAFF for firefighters, and AFSME for all other bargaining units (mainly public works and utilities).

Q19: We would appreciate a copy of your open enrollment guide if available.
A19: attached

Q20: What system or process is currently used by the City for enrollment?
A20: PlanSource

Q21: Please clarify the purpose of Exhibit A on Page 31 of 33. Is this for the proposer to submit responses to the City's Scope of Services, or is this for us to clarify the services being proposed?
A21: Exhibit A is a copy of the scope of services to show what services are expected of the consultant

Q22: Is the current broker handling the placement of other voluntary benefits? If not, is this something you would consider offering?
A22: We offer voluntary life for employ (additional 1x salary) and voluntary dependent life and ad&d.

2. All other terms and conditions remain the same.

The Proposer shall acknowledge receipt of this addendum in the transmittal letter in their Proposal.

The City of Daytona Beach
Kirk Zimmerman, CPPB

The City of Daytona Beach

May 1, 2020—April 30, 2021

2020

Benefits-at-a-Glance

TABLE OF CONTENTS

General Information

What is a "Copayment"?

- A copayment is a pre-determined amount you must pay out-of-pocket when seeing a service provider. It is paid directly to the provider and is due at the time services are rendered.

What is a "Deductible"?

- A deductible is a pre-determined amount that is paid by you before the insurer begins to pay.

What is "Coinsurance"?

- Coinsurance is the percentage paid by the insurer and the percentage paid by you after you have met the deductible.

What is "Precertification"?

- Certain services, such as hospitalization or outpatient surgery, may require prior authorization with your insurer to verify coverage for those services. When required, your participating physician must obtain a precertification for you prior to your treatment.

Where can I find an in-network provider?

- Directories of participating service providers may be found on your insurer's website. If you do not have internet access, you may call member services to find an in-network provider near you.

Should I use Telemedicine, a Convenient Care Center, an Urgent Care Center, or the Emergency Room?

- Telemedicine is a great way to address non-emergency medical conditions and can be done virtually anywhere. Convenient Care Centers (found in many CVS and Walgreens stores) are a great way to address the common cough, cold, and sore throat. The cost is normally the same co-payment as seeing your doctor. Urgent Care Centers are another great alternative to the Emergency Room when your doctor's office is closed. The co-payments are normally a lot less than an Emergency Room visit.

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available May 1, 2020 – April 30, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

For Assistance

Should you have a benefit or claims question, refer to the table below for the appropriate contact. Be sure to have your insurance identification card available when you make your call.

Company/Provider	Plan	Telephone	Website
Florida Health Care Plans An Independent Licensee of the Blue Cross and Blue Shield Association	Medical Insurance Florida Health Care Plans	386-615-4022 877-615-4022	www.fhcp.com
TheStandard	Dental Plan	800-547-9515	www.standard.com
USAble Life	Life/AD&D and LTD Insurance	800-370-5856	www.USAblelife.com
Nationwide is on your side	Deferred Compensation 457 Plan	877-677-3678	www.NRSFORU.com
EMPOWER RETIREMENT	Deferred Compensation 457 Plan	800-695-4952	www.empower-retirement.com
Florida League of Cities, Inc.	Deferred Compensation 457 Plan	800-342-8112	www.flcities.com
ICMA-RC Building Retirement Security	Deferred Compensation 457 Plan	800-326-7272	www.icmarc.org
FRS	Florida Retirement Plan	844-377-1888	www.myfrs.com
FOSTER & FOSTER ACTUARIES AND CONSULTANTS	Police/Fire Pension	239-333-4872	Melody.Hall@foster-foster.com www.foster-foster.com
The City of Daytona Beach Incorporated July 1876	Employee Benefits Coordinator Jacqueline Boyce	386-671-8224	Email BoyceJacqueline@CODB.US
Brown & Brown INSURANCE	Brown & Brown Acct Mgr Teri Kovaleski	386-239-5761	Email tkovaleski@bbdaytona.com

Enrollment Instructions

To enroll in benefits, go to: https://benefits.plansource.com

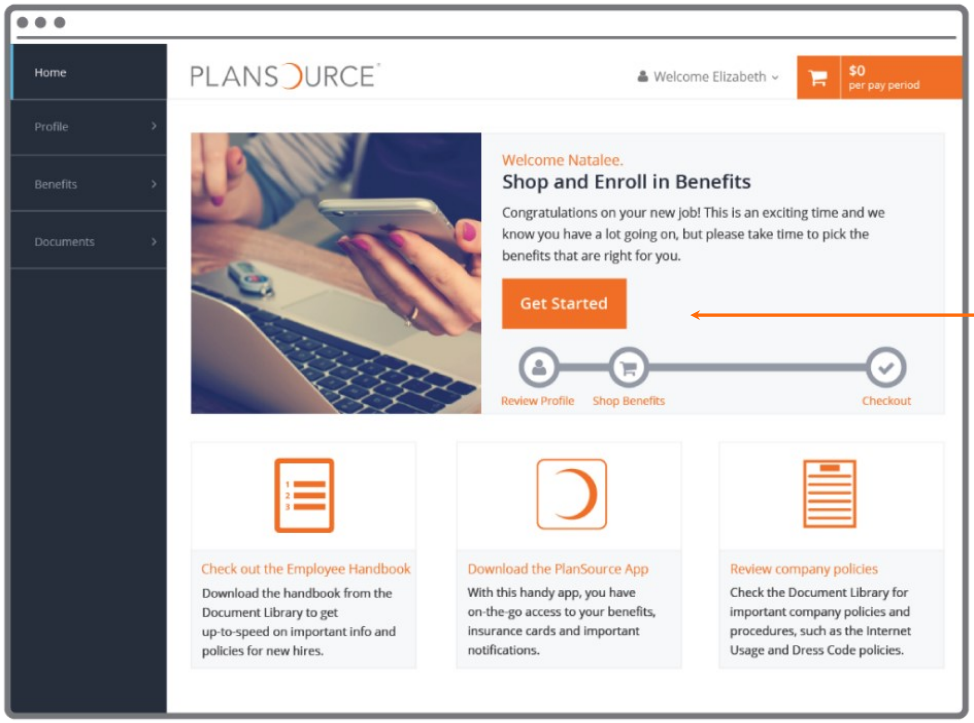
Login Page: Enter username & password to get started.

Username: Your username is the first initial of your first name, up to the first six letters of your last name, and the last four digits of your SSN.

For example, if your name is Taylor Williams, and the last four digits of your SSN are 1234, your username would be twillia1234.

Password: Your initial password is your birthdate in the YYYYMMDD format.

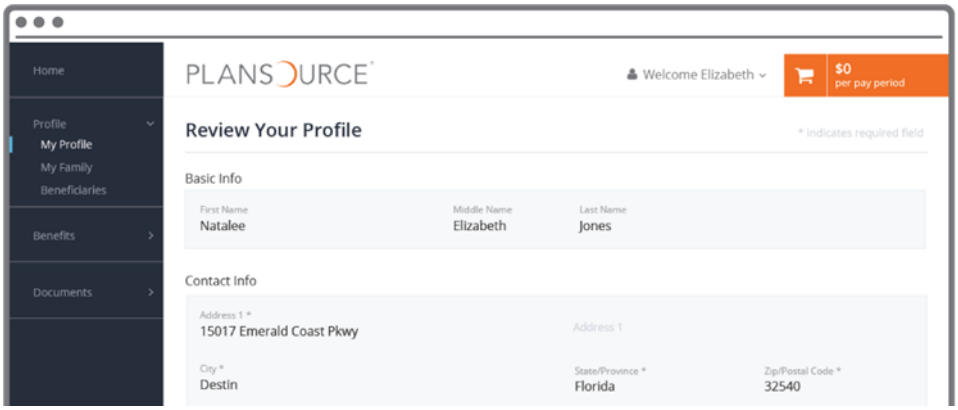
So, if your birthdate is June 4, 1979, your password would be 19790604. The first time you log in, you will be prompted to change your password.



Homepage

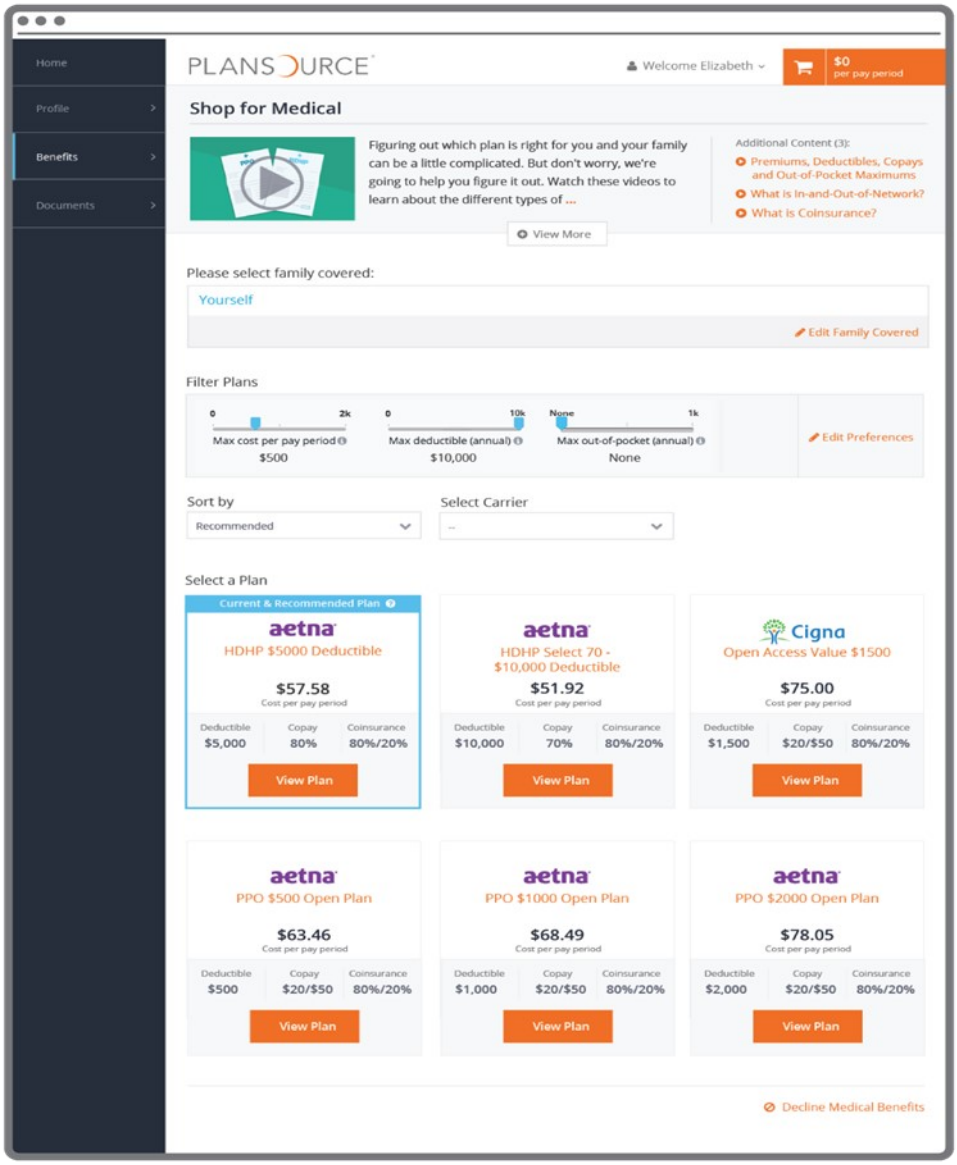
On the Homepage, click "Get Started" to begin.

Enroll in Benefits



Profile

First, you'll be asked to review and update your profile and ensure that all information listed about yourself and your family members is correct.



Shop for Benefits

You can then begin shopping for benefits!

Educational material about the specific plan type is available at the top of the page.

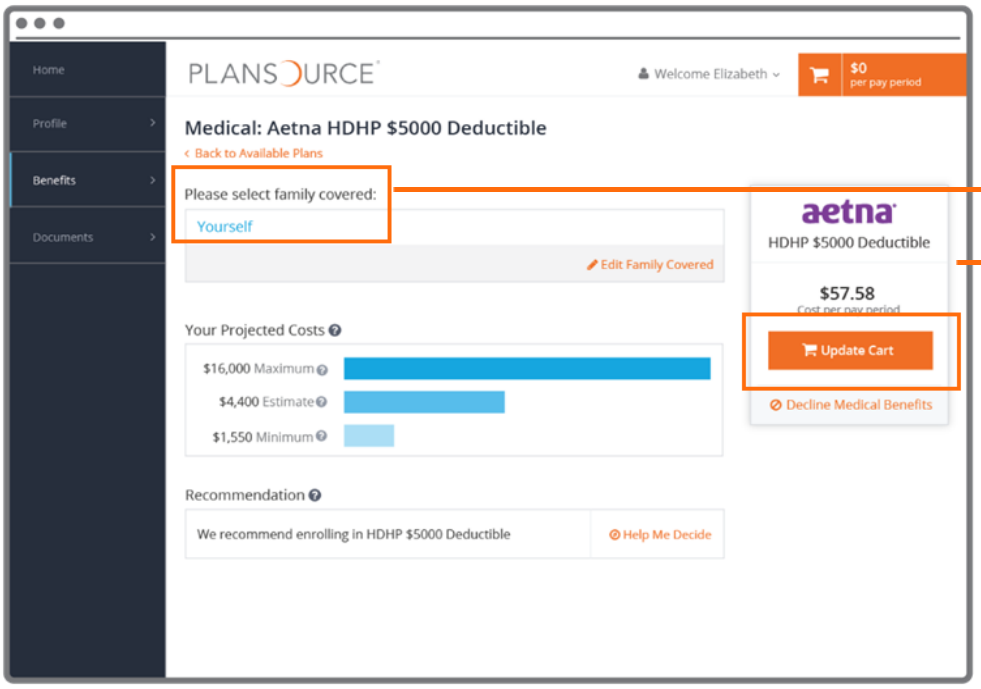
Filter

You will be able to filter available plans based on a variety of criteria.

Plan Overview

Plan choices are displayed on "cards", which provide a brief summary of what is included in the plan. Click a card to get more detail.

Enroll in Benefits



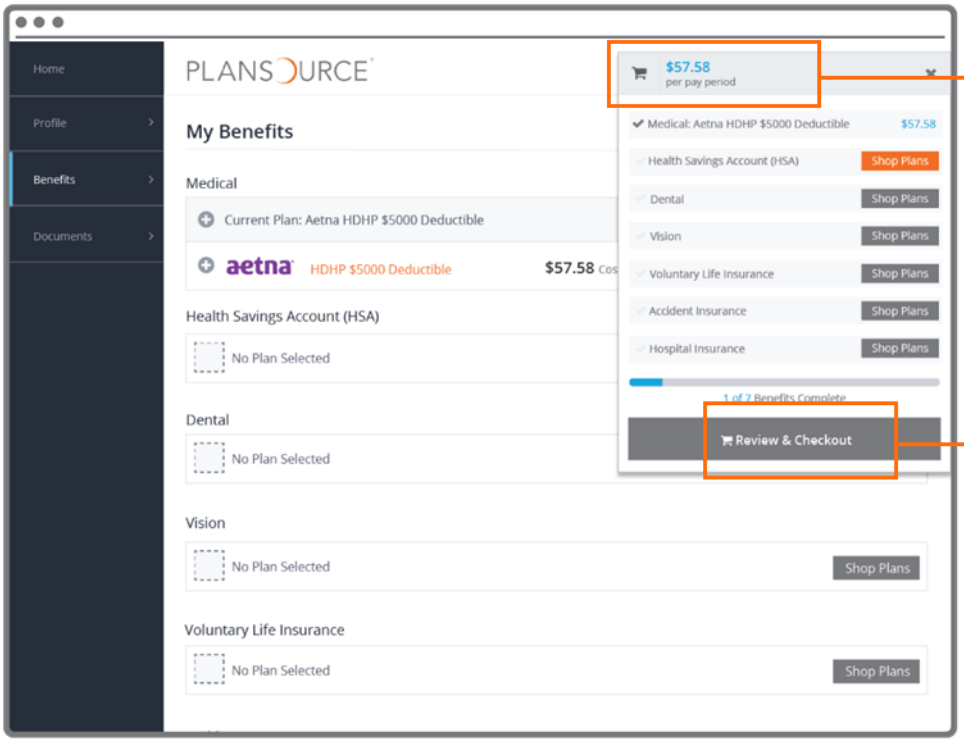
Plan Details

The plan detail page will give you information about each plan, including deductible, cost per pay period and projected costs.

Select Plan

To select a plan, indicate which family members are covered by clicking "edit family covered" and select the card for each family member you'd like to be on the plan.

Click "Update Cart" to choose the plan.



Shopping Cart

The shopping cart displays a running total of your combined benefits costs and shows your progress. You will need to select or decline a plan in each benefit type before you can check out.

Checkout

To finalize your choices, click "Review and Checkout" and then "Checkout".

You must complete the checkout process in order to be enrolled in benefits.

Eligibility & Qualified Life Events

Full time and part time employees who are hired to work 20 hours or more a week are eligible for benefits. Benefits begin on the 1st of the month following 30 days of employment. You may choose to cover only yourself or to enroll eligible dependents. Eligible dependents include:

- Legally Married Spouse
- Dependent Children (to age 26 and under certain circumstances to age 30)
  - Naturally born to you
  - Adopted by you
  - Step Children
  - Under your Foster Care
  - Under your Legal Guardianship

You do not have to elect the same tier of coverage for each benefits you decide to enroll in. For example, you could enroll in "Employee Only" coverage for medical benefits and enroll your entire family in dental coverage.

Changes after Open Enrollment

Benefits with pre-tax deductions are governed by the IRS code Section 125. This regulation does not allow you to change your benefit selections during the year UNLESS you experience a Qualifying Life Event (QLE). If you experience a QLE, you must submit proof of the QLE to Human Resources. Proof of the event and the enrollment change must be completed **within 31 days** of the qualifying event.

Qualifying Life Event (QLE)

All QLEs must be reported to Human Resources within 31 days of the occurrence and documentation provided in order to be eligible to make a change to your benefit enrollments.

Qualified Life Events Include:

- Marriage, Legal Separation, Death or Divorce
- Birth/Adoption/Death/Legal Guardianship of a Child
- A change in residence that would have an adverse impact on your benefit eligibility
- Dependent satisfies or ceases to satisfy eligibility requirements
- Change in employment status
- HIPAA special enrollment rights
- Changes due to a judgment, decree or court order
- Loss/Gain of other group coverage
- Entitlement to Medicare, Medicaid, or Marketplace Qualified Health Plan (QHP)

Medical Insurance Coverage Options

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Provided by Florida Health Care Plans | *www.fhcp.com* | *1 (877) 615 - 4022*

Plan Name	HMO HDHP	HMO	Balanced Triple Opt
Name of Network	**FHCP**	**FHCP**	**FHCP**
Calendar Year Deductible			
Individual Family	$1,600 $3,200 *	$250 $750	$ 500/$1,000/$2,000 $1,000/$2,000/$4,000
Annual Out-of-Pocket Maximum (Includes deductible, copays, coinsurance, if applicable)			
Individual Family	$3,200 $6,400	$3,000 $6,000	$4,000/$4,000/$ 6,000 $8,000/$8,000/$12,000
Coinsurance (Coins) (Amount paid after deductible is met)			
You pay…..	20%	10%	10%/20%/30%
Copays			
Office Visit Specialist Chiropractic Care (20 per CY)	Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance	$20 Copay $35 Copay $20 Copay	$20/$35/Deduct. + Coins. $35/$60/Deduct. + Coins. Deductible + Coinsurance
Adult and Child Wellness Exams	100% Covered	100% Covered	100% Covered / Deduct. + Coins.
Hospital Services			
Inpatient Hospital Per Admission Emergency Room Urgent Care Outpatient Surgical Facility Ambulatory Surgery Center	Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance Deductible + Coinsurance	Deductible + Coinsurance $100 Copay $50 Copay Deductible + Coinsurance Deductible + Coinsurance	Ded.+ Coins./NA/Ded.+ Coins. $100 Copay $75 Copay Ded. + Coins./NA/Ded+Coins. Ded. + Coins./NA/Ded+Coins.
Diagnostic Services			
Independent Facility—Lab/ X-ray Advanced Imaging—(CT, PET, MRI)	Deductible + Coinsurance Deductible + Coinsurance	$0 Lab/ $35 X-ray $150 Copay	$0/NA/Ded. + Coins. $150/Ded.+Coins/Ded.+Coins.
Mental Health/Substance Abuse			
Inpatient (Per Admission) Outpatient	Deductible + Coinsurance Deductible + Coinsurance	Deductible + Coinsurance $35 Copay	Ded.+ Coins./NA/Ded. + Coins. $35 Copay/Ded.+Coins.
Prescription Drugs			
Retail (30/31 day supply): Preferred Generic Non-preferred Generic Preferred Brand Non-preferred Brand Specialty *Mail Order (90 day supply):*	 Ded. + $ 3 Copay / $15 Walgreens Ded. + $10 Copay / $15 Walgreens Ded. + $30 Copay / $35 Walgreens Ded. + $55 Copay / $60 Walgreens Preferred—Ded. + 15% Coins. / Non-preferred—Ded. + 25% Coins. $6/$27/$87/$162 Copay	 $3 Copay / $15 Walgreens $10 Copay / $15 Walgreens $30 Copay / $35 Walgreens $55 Copay / $60 Walgreens Preferred 15% Coins. / Non-preferred 25% Coins. $6/$27/$87/$162 Copay
Non-Network			
Calendar Year Deductible Ind/(Fam.) Out of Pocket Max Ind/(Family) Coinsurance	$3,000/$6,000 $6,000/$12,000 40%	EE bears 100% of cost	See third option above

*Anyone other than single coverage, family deductible applies

Based on full-time weekly pay period

**** Employee Contributions are based on 48 pay periods per year. Deduction will not be taken 4 weeks per year.***

Who is covered	HDHP	HMO	Triple Opt
You only	$ 4.96	$ 18.02	$ 22.34
You+spouse or single parent	$50.31	$ 91.77	$ 98.93
You + family	$66.85	$122.98	$131.63

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Health Savings Account

A health savings account (HSA) combines high deductible health insurance with a tax-favored savings account. Money in the savings account can help pay the costs of qualified medical expenses not covered by medical insurance for you and your dependents. Money left in the savings account earns interest and is yours to keep.

- **For employees who enroll in the Florida Health Care (FHC) High Deductible Health Plan, The City of Daytona Beach will contribute a monthly incentive of $119.88 (59.94/pay period) into your Health Savings Account (HSA) to help offset the cost of your medical expenses (prorated below if enrollment occurs after Open Enrollment). You are not required to make a contribution, but if you do, it cannot exceed the maximum contribution limits for 2020 established by the IRS. :**

MAXIMUM ANNUAL CONTRIBUTIONS	2019	2020
Self - Only Contribution Limit	$3,500	$3,550
Family Contribution Limit	$7,000	$7,100
Catch-up Contribution (Age 55 & Older)	$1,000	$1,000

- EMPLOYEE OWNED ACCOUNT
- Pre-tax contributions
- Health Pay for any qualified medical, dental & vision expenses for yourself, spouse or dependents even if they are enrolled under another medical plan. (See IRS Publication 502 for a complete list of qualified medical expenses– *sample list below*).

Acupuncture	Blood pressure monitor	Crutches/Wheelchair	Lasik/Vision Correction Surgery	Psychologist fees
Alcohol or Drug addiction treatment	Breast Pumps and Supplies/ Accessories	Dental Services	Long-Term Care	Smoking Cessation
Ambulance	Chiropractor Care	Diabetic monitors, test kits, strips & supplies	Medicines (prescription & over-the-counter)	Speech Therapy
Bandages	Coinsurance & Copayments	Fertility Treatment	Oxygen	Sunscreen
Birth Control	Contact Lenses & Glasses	Hearing aids & batteries	Psychiatric Care	Vasectomy

To be HSA-eligible for a month, an individual must:

- Be covered by an HDHP on the first day of the month;
- Not be covered by other health coverage that is not an HDHP (with certain exceptions);
- Not be enrolled in Medicare; and
- Not be eligible to be claimed as a dependent on another person's tax return.

Why might an HSA be the right choice for you?

- It **saves you money**. For individuals with few regular health expenses, paying a traditional health plan premium can feel like throwing money out the window. HDHPs come with much lower premiums than traditional health plans, meaning less money is deducted from your paychecks. Plus, HSAs are basically "cash" accounts, so you may be able to negotiate pricing on many medical services.
- It's **portable**. Even if you change jobs, you get to keep your HSA.
- It's a **tax saver**. Contributions to your HSA are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you pay less in taxes.
- It allows for an **improved retirement account**. Funds roll over at the end of each year and accumulate tax-free, as does the interest on the account. Also, once you reach the age of 55, you are allowed to make additional "catch-up" contributions to your HSA until age 65.
- It puts **money in your pocket**. You never lose unused HSA funds. They always roll over to the next year.

Annual HSA Fund Prorated Based on Eligibility Month

	May 20	Jun 20	Jul 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21
Employee	$1438.56	$1318.68	$1198.80	$1078.92	$959.04	$839.16	$719.28	$599.40	$479.52	$359.64	$239.76	$119.88

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Provided by Florida Health Care Plans | *www.fhcp.FollowMyHealth.com* | *1 (877) 615 - 4022*

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

FHCP.FollowMyHealth.com

All FHCP members can use FollowMyHealth to view lab and test results!

Patients established with staff physicians at FHCP facilities can use FollowMyHealth Secure Messaging to address the following:

Request an appointment or cancel an appointment

Request a prescription renewal

View upcoming scheduled appointments

Send blood pressure checks

Send non-critical messages to your Physician

Log into FHCP.FollowMyHealth.com to register, or download the FollowMyHealth app from your mobile app store today!

If you need help or have questions, contact FHCP Member Services

Email MemberServices@fhcp.com
call 1-877-615-4022 (TRS Relay 711) | Monday - Friday, 8 a.m. to 5 p.m.

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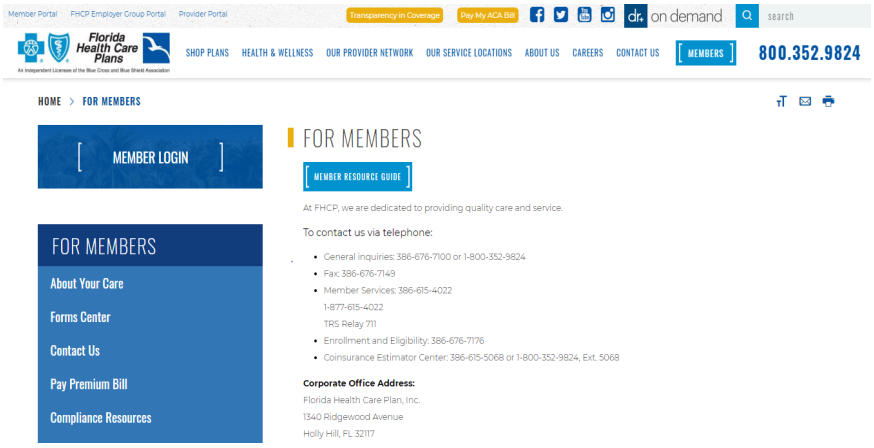
Helpful Tools

By being a Florida Health Care Plans member, you automatically receive services that are free for you and your covered dependents to use. Below are some of these services. For more information, log on to your member portal at https://fhcp.com.

- Find a Provider/Facility
- Health Care Reform Information
- Member Wellness Programs
- Glossary of Health Coverage and Medical Terms
- Summary of Benefits Coverage
- Case Management
- Utilization Management

Florida Health Care Member Portal: Available 24 hours a day, 7 days a week, 365 days a year. The Member Portal has three main sections, Health Portal, Documents Portal and Member Resources. See below for a description of each portal.



The Health Portal: Here you will find the "Welcome to Wellness" Health Risk assessment and Health Management Tool. After you register, you have the opportunity to complete a personalized health risk assessment that will provide insight on different areas of improvement concerning members health. This also allows access to a database of thousands of articles, programs and news related to health and health conditions.

If you utilize a FHCP staff physician, you can access the Patient Portal which will allow you to communicate directly with your FHCP staff physician, make an appointment or request prescription refills.

The Documents Portal: Here you will be obtain view and print your Certificate of Coverage (Member Handbook) which describes your rights and obligations along with FHCP rights and obligations with respect to the coverage and benefits provided. You will also be able to view and print your benefit summary and any applicable benefit riders.

Member Resources: Provides access to common FHCP programs, contacts, resources and forms.

Member Wellness Programs As a FHCP member, you have access information on:

- Smoking Cessation
- Weight Management
- Diabetes
- Acute Low Back and Neck Pain
- Nutrition Program
- Exercise

Matter of Balance - a program designed to manage falls and increase activity levels and balance.

Doctor on Demand See a board certified doctor or licensed psychologist or psychiatrist through live, face-to-face video visits from anywhere. Physicians can diagnose, treat and write prescriptions for most non-emergency medical conditions.* Copays apply.

Nurse Advice Line FHCP has partnered with Carenet Healthcare Services to provide members with access to highly skilled, registered nurses 24 hours a day, 7 days a week, 365 days a year to assist with their health concerns. If you need help understanding a condition or symptom, want to ask a Registered Nurse a confidential health question or wondering where to go for care, the Nurse Advice Line is available to you at no cost. It also has a 24 hour Audio Health Library that contains over 1, 500 English and Spanish topics as well as current community health concerns and announcements. Contact the Nurse Advice Line at 866-548-0727.

FLORIDA HEALTH CARE PLANS

EXTENDED HOURS CARE CENTERS

VOLUSIA/FLAGLER COUNTY

SOME REASONS TO VISIT EXTENDED HOURS CARE CENTERS

VS.

SOME REASONS TO VISIT the EMERGENCY DEPARTMENT

- Acute minor trauma
- Cough, cold or flu
- Strains & sprains
- Minor allergic reactions
- Immunizations
- Low back pain
- Placement of stitches for a cut/laceration
- Removal of stitches
- Urinary tract/bladder infections

- Any life-threatening emergency
- Any severe illness or injury
- Unresponsiveness
- Chest pain
- Weakness on one side
- Inability to speak
- Spine or head injury
- Mental status change
- Difficulty breathing
- Uncontrolled bleeding
- Poisoning

VISITING FHCP's EXTENDED HOURS CARE CENTERS OVER THE EMERGENCY ROOM CAN SAVE YOU TIME & MONEY!

FHCP – Daytona Beach
320 N. Clyde Morris Blvd
Daytona Beach, FL 32114
386-238-3204
Mon—Fri: *7:00 a.m. – 7:00 p.m.*
Sat.: 8:00 a.m. – 12:00 noon

FHCP – DeLand
937 North Spring Garden Ave.
DeLand, FL 32720
386-736-1948
Mon—Fri: *7:00 a.m. – 7:00 p.m.*

FHCP – Edgewater
239 North Ridgewood Ave.
Edgewater, FL 32132
386-427-4868
Mon—Fri: *7:00 a.m. – 7:00 p.m.*
Sat. 8:00 a.m. – 12:00 noon

FHCP – Orange City
2777 Enterprise Rd.
Orange, City, FL 32763
386-774-2550
Mon—Fri: *7:00 a.m. – 7:00 p.m.*
Sat.: 8:00 a.m. – 12:00 noon

FHCP – Ormond Beach
461 S. Nova Rd.
Ormond Beach, FL 32174
386-671-4337
Mon—Fri: *7:00 a.m. – 7:00 p.m.*

FHCP – Port Orange
740 Dunlawton Ave.
Port Orange, FL 32127
386-763-1000
Mon—Fri: *7:00 a.m. – 7:00 p.m.*

Call FHCP Central Scheduling at 386-676-7198 to schedule an appointment at one of our FHCP Facilities

Advanced Urgent Care-Port Orange
1690 Dunlawton Ave., Ste. 120
Port Orange, FL 32127
386-271-2273
Mon—Fri: 7:00 a.m. - 10:00 p.m.
Sat & Sun: 9:00 a.m. - 7:00 p.m.

Pediatric Unscheduled Care Walk-In Clinic
999 S. Volusia Ave. Ste. B
Orange City, FL 32763
386-763-4915
Wed: 1:00 p.m. - 6:00 p.m.

MediQuick Walk-in Clinic
140 Pinnacles Dr.
Palm Coast, FL 32164
386-597-2829
Mon—Fri: 8:00 a.m. - 6:30 p.m.
Sat: 8:00 a.m.-5:30 p.m.
Sun: 10:00 a.m.-4:30 p.m.

MediQuick Walk-in Clinic
6 Office Park Dr
Palm Coast, FL 32137
386-401-5470
Mon—Fri: 8:00 a.m. - 7:30 p.m.
Sat: 8:00 a.m.-5:30 p.m.
Sun: 8:00 a.m.-2:30 p.m.

Avoid unnecessary, costly Emergency Room visits, and save time by using an Extended Hours Care Center (EHCC). EHCC locations offer same-day appointments and are conveniently located throughout the community

For additional questions, please contact Member Services

Commercial Members: 386-615-4022 or 1-877-615-4022 (TTY: 1-800-955-8770).

8:00 a.m. - 8:00 p.m. local time, Mon.—Fri.

Medicare members: 1-833-866-6559 (TTY: 1-800-955-8770), 8:00 a.m. - 8:00 p.m. local time, 7 days a week from Oct. 1 - Mar. 31, except for Thanksgiving and Christmas.

From Apr. 1 – Sept. 30, our hours are 8:00 a.m. - 8:00 p.m. local time, Mon.—Fri.

For a complete list of Urgent Care centers, please visit:

Commercial Members:

www.fhcp.com/providersearch

Medicare members:

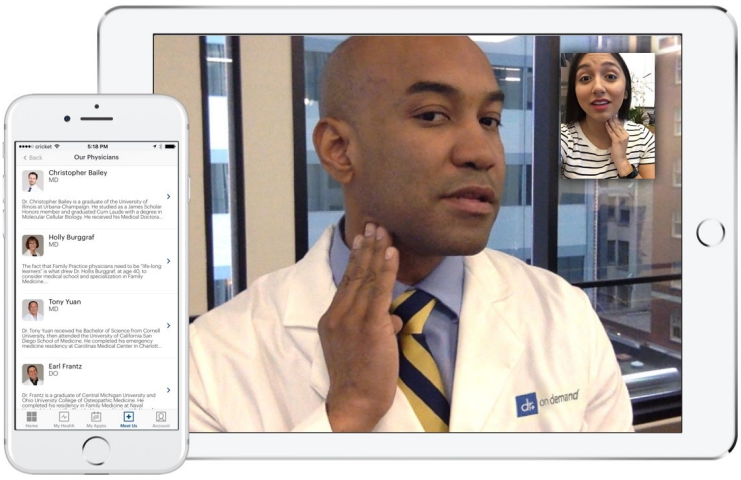
www.fhcpmedicare.com/providersearch

Florida Health Care Plans

WE SEE HEALTH CARE FROM A DIFFERENT POINT OF VIEW - YOURS!

386-676-7110 wellness@fhcp.com

Telemedicine Benefit — Doctor on Demand!



Virtual Visits

Get access to care online.

Any where. Any time.

When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. Now, you don't have to.

A virtual visit lets you see a board certified doctor or a licensed psychologist or psychiatrist through live, face-to-face video visits from anywhere!

Most visits take about 10-15 minutes and doctors can write a prescription*, if needed, that you can pick up at your local pharmacy. And, it's part of your health benefits.

Connect using your computer, smartphone, or tablet (with a front facing camera). You can download the app from the App Store or Google Play. Your device must have a front facing camera. If you are connecting on the web, please use a Safari, Chrome or Firefox browser.

Use virtual visits when:

- Your doctor is not available
- You become ill while traveling
- You are considering visiting a hospital emergency room for a non-emergency health condition

Not good for:

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/ broken bones

Conditions commonly treated through a virtual visit

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection/ Urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

Access virtual visits by logging in to:

https://www.fhcp.com/doctor-on-demand/

Call: 800-352-9824

What is the Cost?

☑ Medical Visit: $10

☑ Psychology Visit: $30

**No controlled drugs prescribed*

Prescription Drug cost comparison:

Use GoodRx and SingleCare's drug price search to compare prices (just like you do for travel or electronics on other sites) for your prescription at pharmacies near you. GoodRx and SingleCare do not sell the medications, but the free websites and mobile apps will tell you where you can get the best deal on them. If you have insurance, your co-pay might not be the best price. Hundreds of generic medications are available for $4 or even free without insurance. Every week both GoodRx and SingleCare collect millions of prices and discounts from pharmacies, drug manufacturers and other sources. GoodRx and SingleCare will show you prices, coupons, discounts and savings tips for your prescriptions at pharmacies near you. There is no cost or membership required to use either of these cost savings tools. Please visit the websites at **www.goodrx.com and www.singlecare.com.**

SingleCare

You can also download the apps on your smartphone. Please note: amounts paid for prescriptions using GoodRx or SingleCare discount programs do not apply toward your medical plan's deductible or annual out of pocket maximum.

Pharmacy Discount Programs:

Before you pay for your next prescription, check to see if they are available for free or at a lower cost than traditional copays. Pharmacies such as Wal-Mart, CVS/Target, and Costco offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30 day Supply. Publix pharmacies also provide a list of free maintenance medications as well as antibiotics that they offer for free (with a prescription from your physician). If your local pharmacy is not listed please check with them to see if they offer any discounts.

Walmart Pharmacy

TARGET
CVS/pharmacy

Publix.

Urgent Care/Walk-In-Clinics Vs. Emergency:

Do not pay more than you have to for medical care. The Emergency room is meant for true emergencies such as life threating illnesses and injuries. Walk-in-clinics are designed to treat common ailments and provide basic primary health care and are typically staffed by nurse practitioners and sometimes a physician's assistant. They are used for common ailments such as: flu/strep throat, allergies, cold and cough. Urgent care facilities are designed to serve patients who are suffering from acute illnesses and injuries which are beyond the capacities of a regular walk-in-clinic, are typically open for extended hours, and are used to treat non-life threating injuries and illnesses. To maximize savings use in-network facilities.

Above are potential ways to save money on the cost of medical care and prescriptions. Actual results may vary.

FHCP Preferred Fitness

You have access to **Florida Health Care Healthy Living Preferred Fitness Program**. Use of the gym facilities are included in the cost of your healthcare. Facilities on the authorized list are authorized to perform a Fitness Evaluation for a small fee. The evaluation consists of Health & weight measurements, blood pressure/pulse rate, body fat percentage, flexibility and range of motion measures, balance and V02 Max– a measure of Oxygen consumption during aerobic exercise. Below is a full list of all the "in-network" gyms located in Volusia, Flagler, Brevard and Seminole Counties that you have access to as part of your health insurance.

ORMOND BEACH / HOLLY HILL					
Anytime Fitness (386) 677-8600	Bodez Fitness Express (386) 672-6464	Gold's Gym (386) 677-4949	Ormond Beach YMCA (386) 673-9622 *Pool Available*	Perfect Storm Hardcore Training Gym (386) 681-8361	Sky Active Strength Studio (386) 947-7642
Planet Fitness (386) 677-4000	Pro Bodies (386) 676-2377	Revive Fitness (386) 676-0009	The Body Exchange (386) 679-7446	Holly Hill YMCA (386) 253-5675 *Pool Available*	Ability Health Services & Rehab (386) 898-0443

DAYTONA BEACH/SOUTH DAYTONA				**PORT ORANGE**	
Ability Health Services ** (386) 763-0084	Elite Muay Thai and Fitness (386) 589-1373	Club Fitness of Daytona (386) 763-9250	Curves For Women (386) 760-2855	4 Ever Fitness (386) 788-5678	Anytime Fitness (386) 243-5640
Halifax Health Wellness Center ** (386) 254-4031	Planet Fitness (386) 253-4300	Greater Fitness (386) 310-7857	Green Acres/Iron Mike's (386) 258-9502	Port Orange Family YMCA (386) 760-9622 *Pool*	
Total Nutrition Gym (386) 238-0244		Workout Anytime Daytona Beach Shores (386) 281-3231			

ST. AUGUSTINE/ST. JOHNS COUNTY		**EDGEWATER/ NEW SMYRNA BEACH**			
Anytime Fitness (904) 297-2300	St. Augustine YMCA (904) 471-9622 *Pool*	Blue Water Therapy (386) 426-7885 *Pool*	Edgewater Fitness Club (386) 847-3269	Heartland Rehabilitation (386) 427-4866	Nautilus By The Sea (386) 426-0079
Solomon Calhoun Community Center Pool (904) 824-6770, *Pool*	Ponte Vedra YMCA (904) 543-9622 *Pool Available*	Vision Fitness 24 (386) 506-9415	NSB Athletic Club (386) 423-4267	Snap Fitness (386) 423-8995	Southeast Volusia Family YMCA (386) 409-9622 *Pool*
Planet Fitness (386) 283-4973					

DELAND/ DELTONA/ ORANGE CITY				
Ability Health Services ** (386) 851-0901	Brooks Rehabilitation (386) 775-7488	Crunch Fitness Deltona (386) 259-5551	DeLand Family YMCA (386) 736-6000 *Pool*	Florida Fitness World (386) 775-1313
Four Townes Family YMCA (386) 532-9622 *Pool*	Next Level Fitness (386) 734-9900	Planet Fitness Deland (386) 873-4911	Latow's Fitness & Nutrition (386) 228-2444	

PALM COAST/BUNNELL					
Ability Health Services & Rehab (386) 445-4945	Belle Terre Swim & Racquet Club (386) 446-6717 *Pool*	East Coast Gym of Flagler (386) 866-1152	Fitness One, Inc. (386) 439-7707 *Pool Available*	Frieda Zamba Aquatics (386) 986-4741 *Pool Available*	Just Train Fitness (386) 264-6706
MPower Fitness (386) 445-2508	Palm Coast Sports Med ** (386) 445-5555	Planet Fitness (386) 446-7462	Silver Synergy With Artie G *St. Thomas Episcopal Church* (386) 931-3485	Studio Z Fitness (386) 446-4333	

BREVARD					
Anytime Fitness Melbourne (321) 242-0525	Anytime Fitness Palm Bay (321) 821-4640	Building Bodies Fitness Center (321) 632-1759	Fitness Club Merritt Island (321) 455-2227	Functionally Fit Fitness Center (321) 877-2090	
Planet Fitness Rockledge (321) 433-1331	Parrish Health & Fitness Center (321) 268-6200 *Pool*	Sunbay Fitness (321) 735-4923	Studio 321 Fitness and Dance (321) 722-5685	Elite Fitness Centers, Inc. (321) 676-1002	Workout Anytime (321) 607-6100

SEMINOLE			
Ability Health Services Sanford (407) 322-3442	Ability Health Services Lake Mary (407) 833-0802	Ability Health Services Altamonte Springs (407) 865-7153	Ability Health Services Oviedo (407) 971-2774

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available May 1, 2020 – April 30, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Dental Coverage—PPO (FOR DUAL OPT)

Provided by The Standard | *www.standard.com* | *1 (800) 547-9515*

Below are your PPO dental plans which gives you freedom to use in-network or out-of-network dentists. Since network providers offer reduced contracted rates, you save money by using network providers for all your dental needs. All benefits received from out-of-network dentists are subject to "reasonable and customary" fees. Any amount that exceeds the dental carrier's "reasonable and customary" amounts is the patient's responsibility.

You can access the dental provider's network and find a dentist near you at https://dentalnetworkpartners.ameritas.com/.

Dental Services	Low Plan	High Plan
Annual Maximum Benefit	$1,000	
Calendar Year Deductible: Individual Family	 $50 $150	 $50 $150
PREVENTATIVE PROCEDURES:	**Deductible Waived**	
Routine Exams Teeth Cleaning—2 per year Bitewing X-rays—1 per year Full Mouth X-rays—1 per 3 years Fluoride Treatments—2 per year (under 14)	Plan pays 100%	Plan pays 100%
BASIC PROCEDURES:	**Deductible Applies**	
General Anesthesia Fillings Root Canals Extractions—Routine / Surgical Periodontal Scaling & Root Planing	Plan pays 80%	Plan pays 80%
MAJOR PROCEDURES:	**Deductible Applies**	
Crowns Bridges Full & Partial Dentures Inlays / Onlays Implants	Plan pays 50%	Plan pays 50%
ORTHODONTIC PROCEDURES:	**Deductible Applies**	
Lifetime maximum * Dependent Children to age 19	$1,000 Plan Pays 50%	
OUT-OF-NETWORK BENEFITS *		
Low Plan (Preventive/Basic/Major/Ortho)	100% / 50% / 25% / 50% (75th of UCR)	
High Plan (Preventive/Basic/Major/Ortho)	100% / 80% / 50% / 50% (90th of UCR)	

* This plan pays 75th percentile (low plan) / 90th percentile (high plan) of the UCR on Out-of-Network charges. This means (Reasonable & Customary) charges generally based on the lowest of (a) the dentist's actual charge; (b) the dentist's usual charge for the same or similar services; or (c) the usual charge of most dentists in the same area for the same or similar services as determined by FCL.

Dental plan rates

Based on your weekly pay period

**** Employee Contributions are based on 48 pay periods per year. Deduction will not be taken 4 weeks per year.***

Who is covered	Low Plan	High Plan
You only	$5.01	$6.27
You + 1	$9.07	$15.49
You + family	$14.38	$24.62

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available May 1, 2020 – April 30, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Get the "Maximum" from your dental benefits

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. In addition, a person earning dental rewards who submits a claim for services received through the dental network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Maximum Carryover is applied to your plan automatically as long as you:

- ☑ Receive at least one covered service during your plan year
- ☑ Are an active member of the plan on the last day of the plan year
- ☑ Don't exceed the claim payment threshold in your plan year
- ☑ The accumulated rollover maximum has not been reached

Plan Annual Maximum	Threshold	Maximum Carryover Amount	Maximum Carryover Account Limit	Annual PPO Bonus
$1,000	$500	$250	$1,000	$100
Maximum possible accumulation for Max Builder and PPO Bonus combined	Dental benefits for the year cannot exceed this amount	Max Builder amount is added to the following years maximum	Maximum Carryover Account cannot exceed $1,000	Additional bonus is earned if the participant sees an network provider

CARRYOVER EXAMPLE

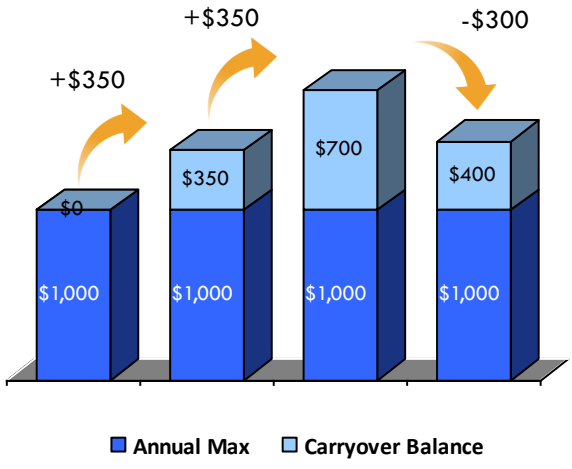
Here's how the benefits work

YEAR ONE: Jane starts with a $1,000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not exceed the $500 Threshold and went to an in-network provider, she receives a $250 carryover plus $100 PPO bonus that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,350. This year, she submits $400 in claims and receives an additional $250 carryover and $100 PPO bonus added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $1,700. This year, she submits $1,300 in claims. All claims are paid due to the Maximum Carryover Amount accumulated.

YEAR FOUR: Jane's Plan Annual Maximum is $1,400 (1,000 Plan Annual Maximum + $400 remaining Maximum Carryover Amount accumulated).



Vision Benefit

Policylink allows you to use up to $100 of dental max towards vision. You don't need to have vision coverage, but can utilize this benefit for glasses, exams, or whatever vision benefit you choose. You can visit any eye doctor.

Vision Services	Allowance
Deductible	None
Eye Exams	$100 maximum
BASIC LENSES	
Single vision	$100 maximum
Bifocal vision	$100 maximum
Trifocal vision	$100 maximum
Lenticular	$100 maximum
Progressive	$100 maximum
FRAMES	
Benefit	$100 maximum
CONTACTS	
Elective / medically necessary	$100 maximum

You count on your income to provide the things you need today and to achieve the dreams you have for tomorrow. But, what would happen if you were suddenly unable to earn a living because of an unexpected accident or illness?

Long-Term Disability

If you become unable to perform your regular job duties for an extended period of time due to sickness, or accidental injury, you can be covered by the long-term disability (LTD) policy.

Your income replacement benefit would equal 60% of your basic monthly earnings with a maximum monthly benefit you can receive of $10,000.

Benefits begin after you have been unable to work for 90 days due to a covered sickness or accident and will continue to be paid for up to 2 years if you are disabled in your own occupation. If you are disabled in any occupation, benefits will be paid until the later of your normal social security age or the benefit duration shown in your LTD summary.

Your LTD benefit will be reduced by any disability income you receive from other sources, such as Social Security, worker's compensation, and/or state disability plans, to provide you with a combined monthly benefit equal to 60% of your basic monthly earnings.

The LTD plan contains a pre-existing condition exclusion. The exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought care within the 3 month period prior to the effective date of coverage until you have been covered under the policy for 12 months or you remain treatment free for a period of 12 consecutive months.

The estimated rates are based on your monthly gross income and your age. The final premium calculations will be performed by USAble Life.

Weekly Premium Calculation

Employees Age	Premium Factor
Under 35	.065
35-44	.100
45-54	.153
55-99	.210

EXAMPLE:

John Doe is 37 and grosses $3,700 per month

$3,700 x .0040=$14.80 monthly premium

$14.80 x 12 months=$177.60 yearly premium

$177.60/48 weekly paychecks=$3.70 weekly premium

This is an estimate of premium cost. Actual deductions will be calculated by USAble Life and may vary slightly due to rounding and payroll frequency.

Life insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help pay your mortgage, rent, run your household, send your children to college, pay off debts, etc.

The City of Daytona Beach provides (**AT NO COST)** to eligible employees 1x the annual salary up to $200,000 of Life and Accidental Death and Dismemberment (AD&D) insurance.

The City also provides the option to purchase additional Life and AD&D insurance for you, your eligible spouse and dependents with USAble Life at a group rate (located on the next page). The coverage is portable and convertible in the event that you separate (terminate employment) from the City of Daytona Beach.

The following are attached to this group term life insurance policy:

Waiver of premium	Portability
Accelerated life benefit	Conversion

To find more information, refer to your USAble Life Certificate of Benefits.

Summary of Voluntary Life Insurance

If you chose to enroll in voluntary life insurance, you may also insure your spouse and eligible dependent children up to the age of 30. A summary of your life insurance coverage is listed in the table below, if you should have questions on this policy, see your Certificate of Benefits, or visit www.USAblelife.com.

Summary of Insurance		
Employee Benefit	1x or 2x annual salary	
Guaranteed Issue (for newly eligible employees)	$300,000	
Maximum Benefit Amount	$300,000	
Spouse & Child Coverage (must choose same option for both)	**Option 1**	**Option 2**
Spouse Amount	$5,000	$10,000
Child Amount	$3,000	$6,000
Child(ren) Coverage	**Option 1**	**Option 2**
Age 14 days to 6 months	$100	$100
Age 6 months to 30 years	$3,000	$6,000

Employee Cost Per Month

If your age is...	Your cost for each $1,000 of supplemental life and AD&D is approximately...
<25	$0.080
25-29	$0.080
30-34	$0.110
35-39	$0.140
40-44	$0.160
45-49	$0.220
50-54	$0.400
55-59	$0.670
60-64	$0.840
65-69	$1.510
70+	$4.150

This is an estimate of premium cost. Actual deductions will be calculated by USAble Life and may vary slightly due to rounding and payroll frequency.

How to figure your voluntary life cost per paycheck:

1. Indicate your elected benefit amount (EBA)
2. Divide EBA by $1,000
3. Enter age rate from cost table
4. Multiply Step 2 by Step 3
5. Multiply Step 4 by 12 then divide by 48 to calculate your cost per paycheck

Additional Information

Age reduction scale:

- 35% of original amount at age 70
- 50% of original amount at age 75

Age-bracketed premiums:

- Premiums increase on plan anniversary after you enter next 5 year age group

Evidence of Insurability (EOI):

- An EOI form is required for employees who do not enroll during their initial eligibility period, want to increase coverage, or add dependent coverage at Open Enrollment.

Dependent Life/AD&D

	Spouse	Child	Cost/month
Option 1	$5,000	$3,000 (6 mo.—30 yr.) $100 (14 days—6 mo.)	$1.70
Option 2	$10,000	$6,000 (6 mo.—30 yr.) $100 (14 days—6 mo.)	$3.40

Employee Assistance Program

Aetna

Resources For Living

EAP
help. when you need it.

Employees and household members can CONFIDENTIALLY address and resolve personal and workplace challenges through the Employee Assistance Program (EAP).

The EAP offers short-term counseling on all aspects of life, including:

- Addictive Behaviors
- Anxiety
- Anger management
- Caregiver counseling
- Coping with a life change
- Depression
- Domestic violence
- Divorce counseling
- Eating disorder situations
- Eldercare issues
- Emotional/psychological concerns
- Family counseling
- Legal or financial stress
- Loss and grieving
- Marital or relationship difficulties
- Organizational change
- Personal and life improvement
- Stress management
- Substance Abuse
- Work stress

CONFIDENTIAL

Assistance is available
24 hours a day, 7 days a week

Toll Free: 800-272-7252

Website: www.mylifevalues.com

Login: CODB Password: CODB

Miscellaneous Benefits

Deferred Compensation 457 Plan

Employees who wish to contribute to a supplemental retirement program are encouraged to join one of the City's Deferred Compensation Plans.

Section 457 of the Internal Revenue Code allows employees to defer a certain portion of their income and invest that deferred income to provide them additional financial security at retirement. Income that is deferred reduces the current tax obligation, and the earnings on the investments also remain tax free until withdrawal, usually at retirement, but no later than age 70 1/2.

Presently, Section 457 allows a maximum of 100% of gross compensation to be deferred, up to $19,500 annually plus an additional $6,500 if age 50 or over during the calendar year.

Nationwide is on your side	EMPOWER RETIREMENT	FLORIDA LEAGUE OF CITIES, INC.	ICMA-RC Building Retirement Security
www.NRSFORU.com	www.enpower-retirement.com	www.flcities.com	www.icmarc.org
877-677-3678	800-695-4952	800-342-8112	844-326-7272

Retirement Plans

Daytona Beach Police and Fire Pension

FOSTER & FOSTER ACTUARIES AND CONSULTANTS

This plan provides retirement benefits to all full-time, sworn Police and Fire personnel.

Membership in this plan is mandatory and members must contribute a percentage of their base pay through payroll deduction on a pre-tax basis. The City also contributes to the plan based upon periodic actuarial valuation.

Employees hired after August 6, 2014, are eligible for retirement upon the attainment of age 55 and the completion of 10 years of credited service or the completion of 25 years of credited service regardless of age. Employees hired before August 6, 2014, are eligible for retirement upon the attainment of age 55 and the completion of 10 years of credited service or the completion of 20 years of credited service regardless of age.

www.foster-foster.com or melody. Hall@foster-foster.com 239-333-4872

Miscellaneous Benefits

Retirement Plans Continued...

Member's normal retirement date shall be the first day of the month coincident with, or next following the earlier of age 55 and completion of 10 years of service or completion of specified number of years of credited services according to hire date. Service connected with death and disability benefits are also provided.

A Deferred Retirement Option Program (DROP) is available to members of the police and fire department who are eligible for normal retirement. DROP allows the member to retire without terminating employment for a maximum of 60 months. At the end of the DROP employment period, the member begins receiving the monthly retirement benefit plus the DROP account balance. Foster & Foster Actuaries and Consultants provides administrative services. For additional information including a copy of the Summary Plan Description, visit their website at www.foster-foster.com, phone number is 239-333-4872. City contact melody.hall@foster-foster.com

Florida Retirement System

General employees are offered a choice of two Florida Retirement System (FRS) plans. Participation and a 3% employee contribution of salary, on a pre-tax basis, are mandatory. The City contributes the majority of the required cost.

The FRS Pension Plan is a traditional retirement plan offering a guaranteed lifetime monthly benefit. All contributions go into a single pension trust fund for all Pension Plan members. Employees hired on or after July 1, 2011, will qualify for a benefit at age 65 with 8 years of service or at any age with 33 years of service.

The FRS Investment Plan is designed for a more mobile workforce. All contributions go into a portable individual account that the employee manages. Vesting occurs after 1 year of service.

Visit the Florida Retirement System's website at www.myfrs.com

844-377-1888

Miscellaneous Benefits

Paid Holidays

New Year's Day

Dr. Martin Luther King's Birthday

Memorial Day

Independence Day

Labor Day

Thanksgiving Day

Christmas Day

Plus:

Two additional days– TBD by City Manager

Birthday

Employee Appreciation Day

Personal Leave

	40 HOUR EMPLOYEE		159 HOUR EMPLOYEE	
LENGTH OF SERVICE	Monthly	Yearly	Monthly	Yearly
1 MONTH through the 7th YEAR	16	192	22.4	268.8
8th YEAR through the 14th YEAR	18	216	25.2	302.4
15th YEAR through the 20th YEAR	20	240	28.0	336.0
20 PLUS YEARS	22	264	30.8	369.6

Pay Schedule and Direct Deposit

Employees are paid on a weekly basis.

The City will deduct for Federal Income Tax, Social Security and Medicare as authorized by law, plus any additional deductions authorized by the employee.

Employees may request their pay or a portion of their pay be directly deposited to a financial institution of their choice by completing an Authorization Agreement for Direct Deposit Form. A voided check or deposit slip must be attached.

Important Notices

Health Insurance Portability and Accountability Act (HIPAA) Notice

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

This Information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of such an event.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Note: The 60 day period for requesting enrollment applied only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30 -day period applied to most special enrollments.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at (312)353-0900. If you have any questions about this notice or the law, please contact your Plan Administrator at the number or location provided in your benefits booklet or Summary Plan Description.

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

Notice of Privacy Practices: Plan administrators, clearinghouses, business associates, and health care providers that transmit health information electronically or use electronic health records may not redistribute or unlawfully use electronic health records without permission from the insured. The insured may request information on how their electronic records are distributed, how frequently they are distributed, and who they are distributed to by contacting the U.S. Department of Health and Human Services.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. If rewards for participating in a wellness program are available, they are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan administrator and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Health Insurance Marketplace Coverage Notice

The Health Insurance Marketplace is available to assist you as you evaluate health insurance options for you and your family. This notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer. The Marketplace is designed to help you find private health insurance and compare private health insurance options. You may also be eligible for a new kind of tax credit under section 36B of Internal Revenue Code that could potentially lower your monthly premium. If you purchase a qualified health plan through the Marketplace, you may lose the employer contribution (if any) to any health benefit plan offered by your employer and all or a portion of that contribution may be excludable from income for federal income tax purposes . More information on the health insurance Marketplace may be found at https:// www.healthcare.gov.

Patient Protection Disclosure

If your plan generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan may designate one for you. For more information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator. If your plan requires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your plan provides coverage for obstetric and/or gynecological care and requires the designation of a primary care provider by a participant or beneficiary, you do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

Women's Health & Cancer Rights Act of 1998

The Women's Health and Cancer Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies. If you have had or are going to have a mastectomy , you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For Individuals receiving mastectomy – related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.
- These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under the health plan offered by your employer.

Please keep this information with your other group health plan documents. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please contact the Human Resources Department.

Important Notices

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Cobra provides eligible individuals and their dependents who would otherwise lose group health coverage as a result of a qualifying life event with an opportunity to continue group health coverage for a limited time period under certain circumstances such as:

- voluntary or involuntary job loss
- reduction in the hours worked
- transition between jobs
- death
- divorce
- and other qualifying life events

If you are entitled to elect COBRA coverage, you will have 60 days (starting on the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by groups with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

The duration of COBRA extends from the date of the qualifying event for a limited period of 18 or 36 months. The length of time depends on the type of qualifying life event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

COBRA Continuation coverage may be terminated earlier than the end of the maximum period for any of the following reasons:

- premiums are not paid in full on a timely basis
- the employer ceases to employ any group health plan
- a qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- a qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage;
- a qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of open enrollment period. For more information on alternatives to COBRA coverage or to find out how COBRA is administered at your workplace reach out to your HR Representative or Plan administrator.

USERRA (Uniformed Services Employment and Re-employment Rights Act)

Reemployment Rights: You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to be free from discrimination and retaliation: If you are a past or present member of the uniformed service, have applied for membership in the uniformed service, or are obligated to serve in the uniformed service then an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection: If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement:

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.
- If you file a complaint with VETS and VETS in unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Note: The rights listed here may vary depending on the circumstances.

Notice of Grandfathered Status

One or more of the health plans offered by your employer could be considered 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 or policy 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 your plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Important Notices

Employee Rights Under the Family and Medical Leave Act (FMLA)

Leave Entitlements: Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

• The birth of a child or placement of a child for adoption or foster care;

• To bond with a child (leave must be taken within one year of the child's birth or placement);

• To care for the employee's spouse, child, or parent who has a qualifying serious health condition;

• For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;

• For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections: While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements: An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

• Have worked for the employer for at least 12 months;

• Have at least 1,250 hours of service in the 12 months before taking leave;* and

• Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave: Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities: Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement: Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint: 1-866-4-USWAGE (1-866-487-9243) or www.dol.gov/whd

Newborn's and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's health Insurance Program (CHIP)

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**COLORADO – Health First Colorado & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711
FLORIDA – Medicaid	**GEORGIA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
INDIANA – Medicaid	**IOWA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 Other Medicaid: Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://chfs.ky.gov Phone: 1-800-635-2570
LOUISIANA – Medicaid	**MAINE – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll Free number for the HIPP program - 1-800-852-3345, ext. 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html Phone: 1-800-701-0710
NEW YORK – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
NORTH CAROLINA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531	

To see if any other states have added a premium assistance program since July 31, 2019 or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov (1-877-267-2323) , menu opt 4, ext 61565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