Your Benefits Overview

January 1, 2019 – December 31, 2019

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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 my 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 an Urgent Care Center or the Emergency Room?

- Urgent Care Centers are another great alternative to the Emergency Room when your doctor's office is closed. The co-payments are less that an Emergency Room visit.

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City of Palm Coast Employee Health Clinic

All City employees and dependents on the Medical Plan can obtain free routine medical care, at our Employee Health Clinic which is operated by MediQuick at the Pinnacles. MediQuick has set aside specific days and hours for the exclusive use of City employees. Services available "free of charge" include, annual physicals, acute medical care such as sore throat, sinus infections, etc. Additionally, lab testing (bloodwork), X-rays, EKG's, minor surgical procedures and treatment of chronic illnesses (i.e., asthma, diabetes, hypertension, etc.).

CITY OF PALM COAST EMPLOYEES' HEALTH CLINIC

MediQuick at the Pinnacles
140 Pinnacles Drive (off Rte. 100)
Palm Coast, FL 32164 (386) 597-2829

	Effective 06/01/2017
MONDAYS	3 – 6 pm
WEDNESDAYS	8 – 10 am
FRIDAYS	1 – 4 pm

BY APPOINTMENT ONLY

Doctor "B"
Brian Bogdanowicz, *MD*

Annual physicals, treatment of chronic illnesses, acute conditions; minor surgical procedures, x-rays, EKGs, lab & misc. testing.

Eligible to use Clinic:

All full time employees whether on City health insurance or not
Family members enrolled in City's health insurance

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Helpful Tools

HSA—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.

- EMPLOYEE OWNED ACCOUNT
- Pre-tax contributions
- Pay for any qualified medical expenses. (See IRS Publication 502 for a list of qualified medical expenses).
- Maximum annual contribution: Employee only coverage: $3,450, Family coverage: $6,900, Age 55 + – additional election of $1,000

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.

Employee Assistance Program (EAP)

With New Directions' comprehensive EAP services, employees and their dependent family members can successfully identify and resolve a wide range of issues at no cost. EAP experts and tools can help individuals address almost any issue, to include some of the following:

Behavioral Consultation

* Relationship and family challenges
* Stress
* Depression
*Work and life coaching
* Substance Abuse

Legal and Financial Consultation

* Divorce
* Landlord/Tenant
* Tax/IRS/Social Security
* Criminal Charges
* Bankruptcy
* Landlord/Tenant Issues

⇒ 6 Visits/Consultations vs. 3 with other EAP's
⇒ Florida Blue Network

Resources available 24/7 365 days per week
Call 800-624-5544 or visit www.ndbh.com

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Medical Coverage Options

Provided by: Florida Blue | 800-352-2583 | www.floridablue.com

Healthcare Services	BlueOptions 3769 PPO	BlueOptions 3160/3161 PPO HDHP with HSA
Name of Network	BlueOptions	
Calendar Year Deductible		
Individual	$500	$1,500
Family	$1,000	$3,000
Annual Out-of-Pocket Maximum (Includes deductible, copays, coinsurance)		
Individual	$2,500	$2,500
Family	$5,000	$5,000
Coinsurance (Coins) (Amount paid after deductible is met)		
You pay…..	20%	20%
Copays		
Primary Care Physician	$35 Copay	Deductible + Coinsurance
Specialist	$50 Copay	Deductible + Coinsurance
Chiropractic Care	$50 Copay	Deductible + Coinsurance
Adult and Child Wellness Exams	$0 Copay	$0 Copay
Hospital Services		
Inpatient Hospital Per Admission	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room	$250 Copay	Deductible + Coinsurance
Urgent Care	$75 Copay	Deductible + Coinsurance
Diagnostic Services		
Independent Facility– Lab / X-ray	Deductible / Deductible + Coinsurance	Deductible / Deductible + Coinsurance
Independent Facility– Adv. Imaging (CT, PET, MRI)	$200 Copay	Deductible + Coinsurance
Prescription Drugs		
Retail (1 month supply)		CALENDAR YEAR DEDUCTIBLE APPLIES
Generic Drugs	$20 Copay	$20 Copay
Preferred Brand Drugs	$40 Copay	$40 Copay
Non-Preferred Brand Drugs	$70 Copay	$70 Copay
Non-Network		
Calendar Year Deductible Ind/(Family)	$2,000 / $4,000	$3,000 / $6,000
Out of Pocket Max Ind/(Family)	$5,000 / $10,000	$5,000 / $10,000
Coinsurance	40%	40%

Medical plan rates based on your bi-weekly deduction

Who is covered	BlueOptions 3769 PPO	BlueOptions 3160/3161 PPO
You Only	$35.31	$16.99
You + Spouse	$96.99	$66.23
You + Child(ren)	$78.21	$47.44
You + Family	$263.54	$173.08

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Dental PPO Options

Provided by: Lincoln Financial | **800-423-2765** | **www.lfg.com**

PPO dental plans give 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 this fee is the patient's responsibility.

Choice Plus PPO Dental Services	In-Network	Out-of-Network
Annual Maximum Benefit	$2,000	
Calendar Year Deductible: Individual / Family	$50 / $150	
PREVENTATIVE PROCEDURES:	**Deductible Waived**	**Deductible Waived**
Routine Exams Teeth Cleaning Bitewing X-rays Full Mouth X-rays Sealants (under age 16) Fluoride Treatments (under age 19)	Plan pays 100%	Plan pays 100%*
BASIC PROCEDURES:	**Deductible Applies**	**Deductible Applies**
Fillings Oral Surgery Root Canal Therapy Periodontics	Plan pays 80%	Plan pays 80%*
MAJOR PROCEDURES:	**Deductible Applies**	**Deductible Applies**
Crowns & Bridges Full & Partial Dentures Implants	Plan Pays 50%	Plan pays 50%*
ORTHODONTICS (coverage for dependent children):		
Lifetime Maximum Coinsurance	$1,000 50% *	

Please see carrier benefit summary for additional plan details.

Includes Rollover Feature

* Percent of maximum allowable charges

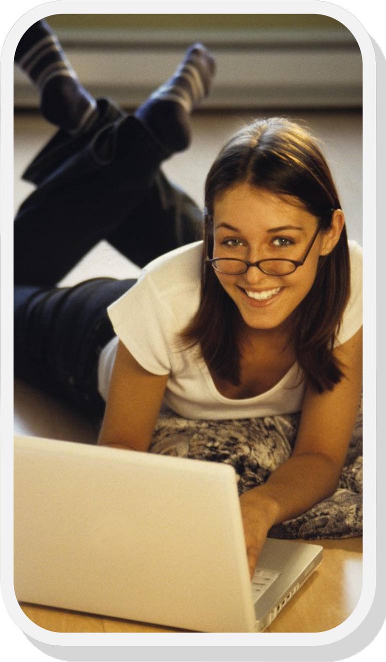
Dental plan rates based on your

Semi-Monthly deduction

Who is covered	PPO Plan
You Only	$17.78
You + Spouse	$33.59
You + Child(ren)	$37.53
You + Family	$53.34

Vision Coverage

Provided by: Humana | 866-537-0229 | www.myhumanavcp.com



Humana Vision 130 - This plan covers eye exams, prescription lenses and frames, or contact lenses for you and your dependents when you receive services from in-network or out-of-network providers. As you can see from the table below, staying in-network cuts costs down and gives you more of a benefit.

To find a participating provider log on to www.myhumanavcp.com.

Vision Coverage Rates: Based on your Semi-Monthly Deduction

Who is covered	Vision Plan
You Only	$2.57
You + Spouse	$5.14
You + Child(ren)	$4.88
You + Family	$7.67

Vision Services	In-Network	Out-of-Network
Eye Exams	$10 Copay	Up to $30 Reimbursement
Frequency	12 months	12 months
BASIC LENSES		
Frequency	12 months	12 months
Single vision	$15 Copay	Up to $25 Reimbursement
Bifocal vision	$15 Copay	Up to $40 Reimbursement
Trifocal vision	$15 Copay	Up to $60 Reimbursement
FRAMES		
Frequency	24 months	24 months
Benefit	$130 allowance	Up to $65 Reimbursement
CONTACTS		
Frequency	12 months	12 months
Elective	$130 allowance	Up to $104 Reimbursement
Medically Necessary	Covered in full	Up to $200 Reimbursement

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Disability Coverage

Lincoln Financial Group

Provided by: Lincoln Financial | 800-423-2765 | www.lfg.com

Short-Term Disability

If you become disabled because of a non-occupational illness or injury and cannot work, you can be covered by the short-term disability insurance policy. Benefits can begin on the 8th day following an accident and the 8th day of a sickness. The short-term disability plan replaces up to 60% of your basic weekly earnings, with a maximum weekly benefit of $1,000. You can receive short-term disability benefits for up to 13 weeks.

The STD 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 and the disability begins within 6 months of the effective date of coverage.

Short –Term Disability Calculation– Cost Per Paycheck	
Annual salary divided by 52= weekly salary	$
Weekly salary times 60%= benefit amount	$
Enter lesser of benefit amount or max weekly benefit ($1,000)	$
Benefit amount times rate ($0.350) divided by 10= monthly premium	$
(Monthly premium times 12) divided by 26= cost per pay period	$

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. The maximum monthly benefit you can receive is $5,000. 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 in own occupation.

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 and the disability begins within 12 months of the effective date of coverage.

City of Palm Coast provides eligible employees Long-Term Disability at NO COST

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Voluntary Life Coverage

Provided by: Lincoln Financial | 800-423-2765 | www.lfg.com

Voluntary Life insurance- you may also insure your spouse and eligible dependent children.

Guarantee Issue	$100,000
Maximum Benefit Amount	$500,000
Increments of…	$10,000
Not to exceed 7x's annual salary	

Spouse Coverage

Spouse Guarantee Issue	$30,000
Maximum Benefit Amount	$250,000
Increments of…	$5,000
Not to exceed 100% of employee amount	

Child(ren) Coverage

14 days-26 years	$10,000

If your age is...	Employee monthly cost for each $1,000 of Voluntary Life	Spouse monthly cost for each $1,000 of Voluntary Life
<29	$0.060	$0.060
30-34	$0.070	$0.070
35-39	$0.090	$0.090
40-44	$0.110	$0.110
45-49	$0.170	$0.170
50-54	$0.260	$0.260
55-59	$0.550	$0.550
60-64	$0.630	$0.630
65-69	$0.940	$0.940
70-74	$2.300	N/A
75-79	$3.200	N/A
80-84	$3.200	N/A
85-89	$3.200	N/A
90+	$3.200	N/A
Child monthly cost for each $1,000 of voluntary life		
Child	$0.166	

Additional Information

Age reduction scale:

35% of original amount at age 75

50% of original amount at age 80

Evidence of Insurability form:

Is required for employees who do not enroll during their initial eligibility period or who want to increase coverage or add dependent coverage at Open Enrollment

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 26 to calculate your cost per paycheck

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Basic Life/AD&D Coverage

Provided by: Lincoln Financial | **800-423-2765** | **www.lfg.com**

Basic Life/ AD&D 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.

City of Palm Coast provides eligible employees
1x's annual salary to a max of $250,000 of basic life insurance and AD&D at no cost.

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

Accelerated Death Benefit

Waiver of Premium

Conversion

Age reduction scale- Benefits will reduce:
35% at age 75
50% at age 80

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

Qualifying Life Events

If you experience any of the below qualifying life events, you must contact Human Resources within 30 days of the event to be able to make changes to your benefits. Proof of the event is required in order to successfully make the requested changes to your plans.

⇒ Marriage	⇒ Divorce or legal separation (subject to State regulations)
⇒ Death of spouse, child or other qualified dependent	⇒ Birth or adoption of child
⇒ Loss of other group coverage	⇒ Change in employment status for employee, spouse or dependent
⇒ Change in residence due to an employment transfer	⇒ Change of dependent status

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City Retirement 401 (a)

Prudential
Bring Your Challenges

Provided by: Prudential | 877-778-2100 | www.prudential.com/online/retirement

Empower Retirement administers the City of Palm Coast Retirement Plan. The City of Palm Coast makes the following contributions to the 401(a) City Retirement Plan for employees, depending on their job classification. Employees do not contribute to this plan. Employees elect their investment choice and can direct their funds into one or more investment options.

City Contributions	
Special Risk Employees	17.5%
Directors	13%
General Employees	10%

VESTING

Vesting refers to the percentage of employer contributions a participant is entitled to receive upon distribution from the Plan. Employer contributions to the Plan, plus any earning they generate, are vested as follows:

General Employees and Directors	
Years of Service	Vesting Percentage
1 Year	20%
2 Years	40%
3 Years	60%
4 Years	80%
5 Years	100%

Special Risk Employees	
Years of Service	Vesting Percentage
1 Year	10%
2 Years	20%
3 Years	30%
4 Years	40%
5 Years	50%
6 Years	60%
7 Years	70%
8 Years	80%
9 Years	90%
10 Years	100%

Withdrawals-401(a) City Retirement Plan

Withdrawals may be made from your 401(a) City Retirement Plan upon one of the following qualifying events as defined by the IRS:

- -Retirement
- -Separation from Service
- -Total Disability
- -Death of participant

Please see Plan documents for special rules that may pertain to fire personnel. Ordinary income taxes will apply to each withdrawal.

City Retirement 457 (b)

Prudential
Bring Your Challenges®

Provided by: Prudential | **877-778-2100** | **www.prudential.com/online/retirement**

The Deferred Compensation Plan offered through Prudential is a benefit available to both full and part-time employees. Through Payroll Deduction, you make pre-tax contributions to your 457(b) Deferred Compensation Plan. You may direct your money into one, or a variety of investment options. Traditional and Roth options are offered.

The maximum contribution amount to the 457(b) plan is as specified by the IRS. For 2018, it is $18,500. For employees 50 years or older, there is a catch-up provision that allows an additional contribution of $6,000. per year.

YOU CAN ENROLL IN THE PLAN AT ANY TIME DURING THE YEAR. Please notify HR whenever you make a change online.

Withdrawals may be made from your 457(b) Deferred Compensation Plan upon one of the following qualifying events; as defined by the IRS:

- Retirement
- Separation from service
- Total Disability
- Unforeseeable Emergency (subject to Plan Limitations)
- Attainment of age 70 1/2
- Death of Participant

Please see Plan documents for special rules that may pertain to Fire personnel.

Loans may be taken from the 457(b) plan, up to 50% of contributions or $50,000. whichever is less. For more information please contact the appropriate Plan Administration Representative.

Tuition Reimbursement

In an effort to improve service to the citizens of the City of Palm Coast and to encourage employees to enhance their productivity and efficiency in their current position and/or which may contribute to advancement and promotional potential, the City of Palm Coast may provide tuition reimbursement according to the following procedures.

Employees who request Tuition Reimbursement, ***must agree to remain in the employ of the City for at least one year*** following completion of the coursework for which they are being reimbursed. ***Employees who separate from employment during this period shall reimburse the City the amounts paid under this policy.*** Each semester, employees must complete a Tuition Reimbursement Program Application and Agreement to Work Form to be eligible for benefits.

This program may be amended or terminated at any time. Reimbursement shall be limited, subject to the availability of funds. The city will reimburse tuition related expenses only. Reimbursement will not be made for Books, fees including internet, labs, travel, equipment, etc.

WHO IS ELIGIBLE

- Full-time City employees who have been employed at least one year.

WHAT SCHOOL CAN I ATTEND

- Employee must enroll in an institution accredited by one of the regional associations recognized by the US Department of Education.
- Course work must be related to either the employee's current position or prepare the employee for promotional opportunities within the City.

WHAT COURSES ARE REIMBURSABLE

- Both academic and technical courses.*
- Bachelor and Masters Degree Courses.**
- Community college courses, correspondence courses, and internet courses.

* - Technical Courses for Water Treatment Plant Only

**The city will reimburse for only (1) Masters degree program and will not reimburse for Doctorate level work.

Technical or other course work	Bachelors Degree Program	Masters Degree Program
Pass = 100%	A = 100%	A = 100%
Fail =0%	B = 75%	B = 50%
	C = 50%	C or Below = 0%
	Below C = 0%	

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REIMBURSEMENT

The City will reimburse employees only to the extent that they are not reimbursed through other programs (i.e., Federal, State or Local aid as well as paid leave, state fire supplemental pay, etc.). No employee will receive tuition funds greater than those actually incurred by the employee. The City will reimburse employees attending private colleges based on the average annual resident rate established by the State of Florida (figures available through Florida Department of Education) for undergraduate or graduate credit hours in the State of Florida Public University System. Employees attending colleges or technical schools that are on the quarter hour or other hourly system will be converted to semester hours for the purpose of reimbursement. The City will not reimburse payment for required textbooks, travel, equipment or other related fees.

APPLICATION PROCESS

To participate in the program, the employee shall submit one signed original, complete Tuition Reimbursement Program Application Form to Human Resources **no later than 2 weeks after the first day of classes**.

NOTE: Failure to apply for program in participation in a timely manner may cause the application to be rejected.

IMPORTANT—A copy of the official course registration and class description must be attached to the form along with an official "paid" tuition receipt. Human Resources shall only notify employees for whom participation is denied for any reason.

Official notice of grades must be submitted to the Human Resources Department within thirty (30) days after completion of the approved course. Requests for reimbursement not received within this time frame shall be paid based upon the ***availability of funds***. Participation is limited to a **maximum of 6 credit hours per semester**. Should there be insufficient funds to cover all approved applications, funds will be disbursed equitably to all applicants. The annual budget for the program shall be included in the Human Resource budget and will be approved by City Council as part of the normal budge process.

Please contact the Human Resources Department for credit hour rates.

Important Notices

Special Enrollment Rights Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Special enrollment rights also may exist in the following circumstances:

- ⇒ If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- ⇒ If you or your dependents become eligible for a State premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.
- ⇒ 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.

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.

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.

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.

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 IRS code that could potentially lowers your monthly premium. If the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such 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

Important Notices

Notice of Rescission: **(a)** ***Prohibition on rescissions*** - (1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual):

I. performs an act, practice, or omission that constitutes fraud

II. makes an intentional misrepresentation of material fact,

as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.) A rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

A cancellation or discontinuance of coverage is not a rescission if -

I. The cancellation or discontinuance of coverage has only a prospective effect;

II. The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRApremiums) towards the cost of coverage;

III. The cancellation or discontinuance of coverage is initiated by the individual (or by the individual's authorized representative) and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or

IV. The cancellation or discontinuance of coverage is initiated by the exchange pursuant (the insured).

Michelle's Law: Michelle's Law protects a postsecondary student from losing full-time student status under an employer's medical coverage if the student is (i) a dependent child of a participant or beneficiary under the terms of the plan; and (ii) enrolled in a plan on the basis of being student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school. A dependent covered under the law is entitled to the same benefits as if the dependent continued to be enrolled as a full-time student. The law also recognizes that changes in coverage (whether due to plan design or a subsequent annual enrollment election) pass through to the dependent for the remainder of the medically necessary leave of absence.

Mental Health Parity & Addiction Equity Act 2008 (MHPAEA): Under the MHPAEA, the financial requirements and treatment limits that group health plans and health insurance issuers apply to mental health or substance use disorder benefits generally cannot be more restrictive than those applicable to medical and surgical benefits. If a plan covers mental health and substance use disorder, MHPAEA provides medical and surgical benefits and mental health and substance use disorder benefits. MHPAEA it must comply with the federal parity requirements. The MHPAEA contains the following parity requirements:

The financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket limits) applicable to mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.

Treatment limitations (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements. Non-quantitative treatment limitations (such as medical management standards, formulary design and determinations of usual, customary or reasonable amounts) are subject to a separate parity requirement.

If medical and surgical benefits are offered on an out-of-network basis, a plan or issuer must also offer mental health and substance use disorder benefits on an out-of-network basis.

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).

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.

Important Notices

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 reach out to your HR Representative or Plan administrator.

Contact your plan administrator or Human Resources to determine how COBRA is administered at your workplace.

CHIP Model Notice

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, 2018. 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**
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+: Colorado.gov/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: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
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: https://dhs.iowa.gov/hawk-i Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://chfs.ky.gov/dms/default.htm 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/medical-assistance.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: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901- 4999	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://dma.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	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/free-or-low-cost-health-care/program-administration/premium-payment-program 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, 2018 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

For Assistance

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

Company/Provider	Group #	Telephone	Website
BLUE CROSS BLUE SHIELD OF FLORIDA Medical	51470	800.352.2853	www.bcbsfl.com
Lincoln Financial Dental, Disability, Life	00027188	800.423.2765	www.lfg.com
HUMANA Vision	791259	866-537-0229	www.myhumanavcp.com
NEW DIRECTIONS EAP	City of Palm Coast	800-624-5544	www.ndbh.com
Prudential	920130 - 457(b) 920140 - 401(a)	877-778-2100	www.Prudential.com/online/retirement