



2016 Employee Benefits Highlights



IMPORTANT CONTACT INFORMATION

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Finance Department	Jennifer Moulton, Senior Pension Payroll Analyst	Phone: (727) 562-4523 jennifer.moulton@myclearwater.com
Parks and Recreation	Regina Novak, Wellness Specialist	Phone: (727) 793-2339 ext. 238 regina.novak@myclearwater.com
Service	Contact Name	Contact Information
Online Enrollment	BenTek	Technical Support: (888) 523-6835 support@mybentek.com www.mybentek.com/clearwater
Employee Health Center	Cigna On-Site Health	Phone: (727) 298-1788
Medical Insurance (Mental Health/Chemical Dependency)	Cigna	Stacy Lambert, Onsite Cigna Representative Phone: (727) 562-4503 Stacy.Lambert@myclearwater.com Customer Service: (800) 244-6224 www.cigna.com
Employee Assistance Program	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.cignabehavioral.com
Dental Insurance	Assurant	Customer Service: (800) 443-2995 www.assurantemployeebenefits.com
	Humana	Customer Service: (800) 342-5209 www.compbenefits.com
Vision Insurance	Humana	Customer Service: (800) 865-3676 www.compbenefits.com
Life Insurance	Human Resources	Phone: (727) 562-4870
Supplemental Insurance	Aflac	Frank D'Ascoli, Agent Phone: (727) 514-7977 frank.dascoli@verizon.net
Flexible Spending Account	WageWorks/Aflac	Frank D'Ascoli, Agent Phone: (727) 514-7977 frank.dascoli@verizon.net www.takecarewageworks.com



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The City of Clearwater’s Employee Benefit Highlights booklet provides summaries of the City’s group insurance offerings for all benefit-eligible employees. This information is provided when you are first hired and during the City’s annual open enrollment. It is important that you make knowledgeable decisions when it comes to your benefits. Please refer to each plan’s Summary Plan Description to learn about any enrollment conditions or coverage stipulations. If you have any questions regarding the contents of this booklet, please contact Human Resources at (727) 562-4870.

BenTek
Technical Support - Email: support@mybentek.com
Technical Support - Phone: (888) 5-BenTek (523-6835)

Online Enrollment with BenTek!

The City of Clearwater provides an electronic enrollment option through BenTek’s Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to make group insurance benefit elections as a new hire, during open enrollment or upon experiencing a qualifying event.

To access the Employee Benefits Center:

1. Log on to www.mybentek.com/clearwater
2. Enter your user name and password.
3. If you have forgotten your username and/or password, click on the link “Forgot Username” or “Forgot Password” and follow the instructions.
4. Click on the “Menu” button and select the appropriate benefit election option (ie. open enrollment, qualifying event, new hire). You can review current elections, learn about your benefit options, and make any elections or changes.
5. You may also update your life insurance beneficiary designation(s).
6. Be sure to click on the submit button when you have completed your selections.
7. You have the option to print out your enrollment confirmation statement containing all your benefit elections for you and your family, including your life insurance beneficiary designations.

Accessible 24 hours a day, you may view your election options, including premiums and carrier information, to help you make informed decisions. You can also log on to the EBC at any time to review your benefits, access carrier links, or update life insurance beneficiaries.

If any technical questions arise while visiting the EBC, please email BenTek Support at support@mybentek.com or call (888) 5-BenTek (523-6835), Monday through Friday, during regular business hours.

To access your group insurance benefits online, log on to www.mybentek.com/clearwater

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for each medical plan option is **provided as a supplement** to this booklet which is being distributed to new hires and existing employees during open enrollment. These summaries are an important item in understanding your benefit options. Free paper copies of the SBC documents are available upon request or as follows:

From:	City of Clearwater Human Resources Department
Address:	100 South Myrtle Avenue Clearwater, FL 33756
Phone:	(727) 562-4870
City Website:	http://clearwater/Departments/humres/Benefits/medical.asp
BenTek Enrollment Website:	www.mybentek.com/clearwater

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the actual group certificate of coverage can be reviewed and/or obtained by contacting Human Resources or at the following web address: www.mybentek.com/clearwater.

If you have any questions about the plan offerings or coverage options, please contact Human Resources at (727) 562-4870.

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

Employee Eligibility

Employees working a minimum of 37.5 hours per week are eligible to participate in all City insurance plans. Eligible employees working an average of 30 to 37.5 hours per week may also participate in the City's insurance plans, excluding the life insurance and retirement benefit offerings. Coverage will be effective the 1st of the month following the date of hire. For example: If you are hired on April 11th, your coverage will begin on May 1st.

Termination

If you separate employment from the City, insurance will continue through the end of the month in which the separation occurred. COBRA continuation of coverage may be available as applicable by law (see page 17).

Dependent Eligibility

A dependent is defined as the legal spouse/domestic partner and/or dependent child(ren) of the participant or spouse/domestic partner. The term "child" includes any of the following:

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

Medical Coverage: Dependent children may be covered through the end of calendar year in which they turn 26.

Over-age dependents may continue to be covered under the medical plan to the end of the calendar year in which the dependent reaches the age of 30, if the dependent meets the following requirements:

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

Please see the Taxable Dependents section below if you are covering eligible over-age dependents.

Dental Coverage: Dependent children may be covered through the end of the month in which they turn 26.

Vision Coverage: Dependent children may be covered through the end of the month in which they turn 26.

Disabled Dependents

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

1. The dependent is physically or mentally disabled, primarily supported by you and incapable of self-sustaining employment (prior to age 26); AND
2. The dependent is eligible for coverage under the group medical plan; AND
3. The dependent has been continuously insured; AND
4. Coverage with the City began prior to the age of 26.

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

Taxable Dependents

Employees covering adult children under the City's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, employees insuring over-age dependents will see the insurance premium deductions on a post-tax basis and any amount subsidized by the employer will be reported as (imputed income) to the employee. Check with Human Resources for further details if you are covering an adult child who will turn 27 any time in the upcoming calendar year or for more information.

Domestic Partner

A Domestic Partner and any eligible dependent(s) will be provided the same benefits afforded to all employees and eligible dependents excluding American Family Life Assurance Company of Columbus (Aflac) and Family Medical Leave Act (FMLA). A Domestic Partner is defined as a person of the same or opposite sex with whom an employee or retiree has established a domestic partnership in accordance with the Policy, rules, and procedures determined by the City and will be required to complete an Affidavit of Domestic Partnership. IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependents of a domestic partner will see the insurance premium deductions on a post-tax basis and any amount subsidized by the employer will be reported as "imputed income" to the employee.

A Domestic Partnership will be required to meet all of the following eligibility requirements:

1. Both individuals are at least eighteen (18) years old and mentally competent to consent to a contract.
2. Both are each other's sole domestic partner and intend to remain so indefinitely.
3. Both have common residence and at the time of submitting an affidavit and have resided together on a continuous basis for the preceding six (6) months intending to continue the arrangement.
4. Both are not married under Florida law nor are domestic partners with anyone else and have not been so during the preceding six (6) months.
5. Both are not related by blood in any way that would prohibit legal marriage in the State of Florida.
6. Both share responsibility for a significant measure of each other's common welfare and financial obligations.

You may contact Human Resources for further details and rates if you are covering a domestic partner at any time during the upcoming plan year.

IRS Code Section 125

Premiums for medical, dental, vision insurance, and/or certain supplemental policies and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) on a pre-tax basis to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made **ONLY** during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event. Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, if an event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples of qualifying events

- Marriage, divorce or registration/termination of Domestic Partnership
- Birth of a child
- You gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or dependent(s) terminate or start employment
- An increase or decrease in your work hours causing eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)

IMPORTANT

The City of Clearwater operates under strict IRS Guidelines, therefore if you experience a qualifying event, you must notify the Human Resources Department within 30 days of the qualifying event (or within 60 days for a newborn or adoption) in order to make the appropriate changes to your coverage. After 30 days, your request for changes in coverage may be denied and/or you may be responsible for any claim or expense incurred by you or a dependent who does not meet eligibility requirements.

If your qualifying event is approved, you will have the option to have your coverage become effective on the date proof was provided to City or on the first day of the month following the date you provided the City proof; except in the event of a newborn or adoption, in which you may elect coverage effective the date of birth or adoption (if you notify within 30 days) in addition to the previous options. You may be required to furnish valid documentation supporting a change in status or qualifying event. Please contact the Human Resources Department if you have any questions or require assistance regarding a qualifying event.

City of Clearwater Employee Health Center

The Employee Health Center is available to employees, retirees, and their eligible dependents enrolled in the City's medical insurance plan. The EHC provides the care you and your dependents need for all non-emergency illnesses. Schedule an appointment with the medical staff to learn more about the Employee Health Center or refer to your **Summary of Benefits and Coverage (SBC)**.

The EHC is now administered by Cigna On-Site Health, a third-party vendor. Utilization is entirely voluntary. All visits with Employee Health Center staff are completely confidential and no personal information is shared with your employer.

Why choose the Employee Health Center?

- Full range of primary care services available for no charge
- Dedicated appointment times
- No charge for prescriptions dispensed at the EHC (a list of available Rx's can be found on the City's Intranet site)
- 100% confidential and HIPAA compliant

Upon enrollment in the City's medical plans, participants will have access to register and create an account on the patient portal. The patient portal will allow you to view your personal health history and personal health information, as well as to connect with EHC doctors.

To schedule an appointment at the Employee Health Center, contact Cigna On-Site Health by calling (727) 298-1788.

Hours of operation are 7:00 a.m. to 5:00 p.m., Monday through Friday. Appointments are **required**; however, walk-ins may be accommodated based on availability and/or the severity of the issue.

Please Note: Employees will be allowed up to one hour, with no charge to their sick leave, to attend a scheduled appointment at the Employee Health Center.

Employee Health Center
Powell Professional Center
401 Corbett Street, Suite 240
Clearwater, FL 33756
(727) 298-1788



The Health Center will be closed New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving & day after, and Christmas Day.

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

The City provides medical insurance through Cigna to benefit-eligible employees. The Employee and Retiree costs are listed in the premium tables below. For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided.

Cigna Healthcare will continue to be the provider for the City's medical insurance in 2016. There are three separate plan options available. The plan you are enrolled in will depend on whether or not you have completed a Personal Health Assessment (PHA) through the health center staff or the equivalent. If you have not completed a PHA, you will be enrolled in the Cigna LocalPlus Base Plan. If you have completed a PHA, you will have the option to enroll in either the Cigna LocalPlus PHA or Cigna OAP PHA Buy-Up plan. Please note that if you are unable to complete the PHA, upon approval, an alternative may be available.

2016 Medical Insurance - Cigna LocalPlus PHA Plan

Employee Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	\$0.00
Employee + One Dependent	\$141.74
Employee + Family	\$297.70
Dual Coverage	\$0.00

Retiree/COBRA* Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	\$661.78
Retiree + One Dependent	\$1,133.93
Retiree + Family	\$1,860.63

*A 2% administrative charge will be added to the monthly rate for COBRA.

2016 Medical Insurance - Cigna LocalPlus Base Plan

Employee Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	\$0.00
Employee + One Dependent	\$141.74
Employee + Family	\$297.70
Dual Coverage	\$0.00

Retiree/COBRA* Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	\$661.78
Retiree + One Dependent	\$1,133.93
Retiree + Family	\$1,860.63

*A 2% administrative charge will be added to the monthly rate for COBRA.

2016 Medical Insurance - Cigna Open Access Plus (OAP) PHA Buy-Up Plan

Employee Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	\$25.48
Employee + One Dependent	\$185.40
Employee + Family	\$369.34
Dual Coverage	\$71.63

Retiree/COBRA* Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	\$712.74
Retiree + One Dependent	\$1,221.24
Retiree + Family	\$2,003.89

*A 2% administrative charge will be added to the monthly rate for COBRA.

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The City provides medical insurance through Cigna to benefit-eligible employees. The Employee and Retiree costs are listed in the premium tables to the left. **For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided. Contact Cigna's Customer Service at (800) 244-6224 or visit www.cigna.com.**

How the Deductible and Co-Insurance Works

- For services requiring a co-payment, you pay only the co-payment amount each time you receive the service.
- For services requiring co-insurance, you pay the full cost of services up to the deductible amount, and then you pay a percentage (co-insurance) of the remaining cost of services up to your out-of-pocket limit.
- Once you reach your out-of-pocket limit, the plan pays the full cost of any services (including prescriptions) normally covered by your plan.
- Only services requiring co-insurance go toward satisfying the deductible. All services, including the deductible, co-insurance and co-payments, including prescription drugs, will go toward satisfying the out-of-pocket limit.

Please remember that out-of-network providers may balance bill for charges that exceed the allowed billed amount, even once the Out-of-Pocket Limit has been reached.

Cigna LocalPlus Plans (PHA and Base plan)

To search for a participating provider please contact Cigna's Customer Service or visit www.cigna.com. Select the "Find a Doctor" tab and then choose "If your insurance plan is offered through work or school... Find a Doctor or Dentist using this Directory" option. Under "Select a Plan," click "Pick," choose "**LocalPlus**" for your plan type then click "Choose." Complete the additional search criteria and select "Search."

Cigna OAP PHA Buy-Up Plan

To search for a participating provider please contact Cigna's Customer Service or visit www.cigna.com. Select the "Find a Doctor" tab and then choose "If your insurance plan is offered through work or school... Find a Doctor or Dentist using this Directory" option. Under "Select a Plan," click "Pick," choose "**Open Access Plus, OA Plus, ChoiceFund OA Plus**" for your plan type, then click "Choose." Complete the additional search criteria and select "Search."

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Network	CIGNA LocalPlus	
Calendar Year Deductible (CYD)	In-Network	Out-of-Network
Single	\$2,000	\$2,000
Family	\$4,000	\$4,000
Coinsurance	In-Network	Out-of-Network
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Maximum	In-Network	Out-of-Network
Single	\$3,500	\$3,500
Family	\$7,000	\$7,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services	In-Network	Out-of-Network**
Primary Care Physician (PCP) Office Visit	\$40 Copay	30% After CYD
Specialist Office Visit	\$60 Copay	
Non-Hospital Services; Freestanding Facility	In-Network	Out-of-Network**
Clinical Lab (Blood Work): Quest or LabCorp*	No Charge	30% After CYD
X-rays/Advanced Imaging (MRI, PET, CT) (i.e. West Coast Radiology & Rose Radiology)		
Outpatient Surgery in Surgical Center (Per Visit)	\$300 Copay + 10% After CYD	\$300 Copay + 30% After CYD
Outpatient Physician Services	10% After CYD	30% After CYD
Hospital Services	In-Network	Out-of-Network**
Hospital Pre-admission Requirement	Yes, or you pay 100%	Yes, or you pay 100%
Inpatient (Per Admission)	\$500 PAD + 10% After CYD	\$500 PAD + 30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$150 Copay	\$150 Copay
Ambulance (Emergency Services Only)	10% After CYD	10% After CYD
Urgent Care Center (Per Visit; Waived if Admitted)	\$75 Copay	\$75 Copay
Outpatient Rehabilitation	In-Network	Out-of-Network**
Facility Charge (60 visits annual maximum)	\$60 Per Visit	30% After CYD
Mental Health/Substance Abuse	In-Network	Out-of-Network**
Inpatient (Prior Authorization is Required)	\$100 Copay Per Admission	\$100 Copay Per Admission
Outpatient Facility (Prior Authorization is Required)	\$10 Copay Per Visit	30% Coinsurance
Prescription Drugs (Retail 30 Day Supply)	In-Network	Out-of-Network**
Generic	\$30 Copay	30% Coinsurance
Preferred Brand Name	\$40 Copay	
Non-Preferred Brand Name	\$60 Copay	
Mail-Order Drug (90 Day Supply)	2x Retail Copay	Not Covered

PAD = Per Admission Deductible

*Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please be sure to confirm they are contracted with Cigna's LocalPlus Network prior to receiving services.

**Out-of-Network Balance Billing: For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Summary of Benefits and Coverage (SBC).

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Network	CIGNA LocalPlus	
Calendar Year Deductible (CYD)	In-Network	Out-of-Network
Single	\$3,000	\$3,000
Family	\$6,000	\$6,000
Coinsurance	In-Network	Out-of-Network
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Maximum	In-Network	Out-of-Network
Single	\$4,000	\$4,000
Family	\$8,000	\$8,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services	In-Network	Out-of-Network**
Primary Care Physician (PCP) Office Visit	\$50 Copay	40% After CYD
Specialist Office Visit	\$75 Copay	
Non-Hospital Services; Freestanding Facility	In-Network	Out-of-Network**
Clinical Lab (Blood Work): Quest or LabCorp*	No Charge	40% After CYD
X-rays/Advanced Imaging (MRI, PET, CT) (i.e. West Coast Radiology & Rose Radiology)		
Outpatient Surgery in Surgical Center (Per Visit)	\$300 Copay + 20% After CYD	\$300 Copay + 40% After CYD
Outpatient Physician Services	20% After CYD	40% After CYD
Hospital Services	In-Network	Out-of-Network**
Hospital Pre-admission Requirement	Yes, or you pay 100%	Yes, or you pay 100%
Inpatient	\$500 PAD + 20% After CYD	\$500 PAD + 40% After CYD
Physician Services at Hospital	20% After CYD	40% After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$150 Copay	\$150 Copay
Ambulance (Emergency Services Only)	20% After CYD	20% After CYD
Urgent Care Center (Per Visit; Waived if Admitted)	\$75 Copay	\$75 Copay
Outpatient Rehabilitation	In-Network	Out-of-Network**
Facility Charge (60 visits annual maximum)	\$75 Per Visit	40% After CYD
Mental Health/Substance Abuse	In-Network	Out-of-Network**
Inpatient (Prior Authorization is Required)	\$100 Copay Per Admission	\$100 Copay Per Admission
Outpatient Facility (Prior Authorization is Required)	\$10 Copay Per Visit	40% Coinsurance
Prescription Drugs (Retail 30 Day Supply)	In-Network	Out-of-Network**
Generic	\$30 Copay	40% Coinsurance
Preferred Brand Name	\$40 Copay	
Non-Preferred Brand Name	\$60 Copay	
Mail-Order Drug (90 Day Supply)	2x Retail Copay	Not Covered

PAD = Per Admission Deductible

*Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please be sure to confirm they are contracted with Cigna's LocalPlus Network prior to receiving services.

****Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Summary of Benefits and Coverage (SBC).

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Network	CIGNA Open Access Plus (OAP)	
Calendar Year Deductible (CYD)	In-Network	Out-of-Network
Single	\$3,000	\$3,000
Family	\$6,000	\$6,000
Coinsurance	In-Network	Out-of-Network
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Maximum	In-Network	Out-of-Network
Single	\$4,000	\$4,000
Family	\$8,000	\$8,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services	In-Network	Out-of-Network**
Primary Care Physician (PCP) Office Visit	\$50 Copay	40% After CYD
Specialist Office Visit	\$75 Copay	
Non-Hospital Services; Freestanding Facility	In-Network	Out-of-Network**
Clinical Lab (Blood Work): Quest or LabCorp*	No Charge	40% After CYD
X-rays/Advanced Imaging (MRI, PET, CT) (i.e. West Coast Radiology & Rose Radiology)		
Outpatient Surgery in Surgical Center (Per Visit)	\$300 Copay + 20% After CYD	\$300 Copay + 40% After CYD
Outpatient Physician Services	20% After CYD	40% After CYD
Hospital Services	In-Network	Out-of-Network**
Hospital Pre-admission Requirement	Yes, or you pay 100%	Yes, or you pay 100%
Inpatient	\$500 PAD + 20% After CYD	\$500 PAD + 40% After CYD
Physician Services at Hospital	20% After CYD	40% After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$150 Copay	\$150 Copay
Ambulance (Emergency Services Only)	20% After CYD	20% After CYD
Urgent Care Center (Per Visit; Waived if Admitted)	\$75 Copay	\$75 Copay
Outpatient Rehabilitation	In-Network	Out-of-Network**
Facility Charge (60 visits annual maximum)	\$75 Per Visit	40% After CYD
Mental Health/Substance Abuse	In-Network	Out-of-Network**
Inpatient (Prior Authorization is Required)	\$100 Copay Per Admission	\$100 Copay Per Admission
Outpatient Facility (Prior Authorization is Required)	\$10 Copay Per Visit	40% Coinsurance
Prescription Drugs (Retail 30 Day Supply)	In-Network	Out-of-Network**
Generic	\$30 Copay	40% Coinsurance
Preferred Brand Name	\$40 Copay	
Non-Preferred Brand Name	\$60 Copay	
Mail-Order Drug (90 Day Supply)	2x Retail Copay	Not Covered

PAD = Per Admission Deductible

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Employee Assistance Program

Cigna Behavioral Health
Customer Service: (877) 622-4327
www.cignabehavioral.com
Employer ID: clearwater

The City provides at no cost to you a comprehensive Employee Assistance Program (EAP), which is available to you and each member of your family covered under the City's medical insurance through Cigna's Employee Assistance Program. The EAP offers unlimited telephonic counseling and up to 5 face-to-face sessions, per member per issue, with a licensed professional through a confidential program that is protected by state and federal laws. The EAP program is available to help you gain a better understanding of problems that affect you, locate the best professional help for your particular problem, and decide upon a plan of action. All EAP counselors are professionally trained, certified, and licensed in their fields.

What is an Employee Assistance Program?

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

- Anxiety
- Stress
- Depression
- Life improvement
- Family and/or marriage problems
- Grief and bereavement
- Substance abuse
- Gambling and other addictions
- Legal and financial concerns

Are Services Confidential?

Yes. Voluntary participation in EAP services is completely confidential. However, participation in the EAP may be the direct result of a Management Referral (a referral initiated by a supervisor or manager), in which case permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager may be requested or required. The referring supervisor will not receive specific information regarding the referred employee's care. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

***Please Note:** Mental Health and Substance Abuse is a covered medical benefit under the City's group medical insurance plans with Cigna. However, there is still some assistance available through the City's EAP program that may be beneficial for acute situations, such as face-to-face or telephonic counseling sessions. For more information regarding the EAP offerings for these conditions, please contact Customer Service or log onto the cignabehavioral.com site using the employer ID above.*



Dental Insurance: Assurant and Humana Plans

Assurant

Customer Service: (800) 443-2995
www.assurantemployeebenefits.com

Humana

Customer Service: (800) 342-5209
www.compbenefits.com

The City offers a variety of dental insurance options to eligible employees through Humana and Assurant Employee Benefits. Dental insurance is 100% employee paid and semi-monthly premiums are deducted from your paycheck 24 times a year. The employee costs are shown on the premium table below. A brief description of the dental plan options and a summary of the benefits are shown below and on the following page. For detailed coverages, exclusions, and stipulations, please refer to the carrier's benefit summary or contact the carrier's customer service number.

The Prepaid Dental DHMO Plans: Assurant Low Option, Humana CS150, Humana Advantage Open Access

If you enroll in a prepaid dental plan, you must choose your dentist from a list of participating providers and make copays for your general dental needs. If a specialist is required, you must select a specialist from a list of participating specialists. You can either pay the appropriate copays from the provider's Schedule of Benefits and Subscriber copays or pay at discounted prices. Covered members must be treated by in-network dentists or specialists. Prepaid dental plan highlights include the following:

- NO deductibles or claim forms
- NO maximum benefit level
- NO preexisting condition limitation
- NO benefit waiting period for any service

The PPO/Traditional (Indemnity) Dental Insurance Plan: Humana Elite Preferred 510

Humana provides a PPO/Traditional (indemnity) dental plan that gives you freedom of choice when selecting your dental care providers. You pay the cost of dental care at the time you receive service and file a claim form. After satisfying a deductible, you will be responsible for the applicable coinsurance level depending on the type of dental service performed. Highlights of the PPO/Traditional (indemnity) Plan include the following:

- Freedom to visit a dentist of your choice at any time
- Claims must be filed
- Reduced out-of-pocket expenses when visiting participating PPO dentist
- Annual Deductible - \$50 per participant for basic, major, and orthodontic services – maximum of 3 deductibles assessed per family
- Annual benefit maximum - \$1,000 per person
- Orthodontics - \$1,000 lifetime maximum
- No benefit waiting period for preventive and basic services; 12-month wait for major and orthodontic services

Contact Information

If you elect dental coverage, identification cards will be furnished by the carrier at the time your coverage becomes effective. If you have questions regarding claims, services or providers, please call the carrier's customer service department.

Dental Insurance – Active Employees 2016 Semi-Monthly Pay Period Premium Deductions

Tier of Coverage	Assurant Low Option	Humana CS150	Humana Advantage Open Access	Humana Elite Preferred 510
Employee Only	\$4.25	\$9.25	\$13.93	\$19.65
Employee + One Dependent	\$7.19	\$17.21	\$25.95	\$39.83
Employee + Family	\$11.33	\$22.40	\$33.78	\$58.72

Dental Insurance – Retirees 2016 Monthly Premium Rates

Tier of Coverage	Assurant Low Option	Humana CS150	Humana Advantage Open Access	Humana Elite Preferred 510
Retiree Only	\$8.49	\$18.50	\$27.86	\$39.30
Retiree + One Dependent	\$14.37	\$34.42	\$51.90	\$79.66
Retiree + Family	\$22.66	\$44.80	\$67.56	\$117.44

Prepaid Dental DHMO Summary of Benefits		Assurant Low Option Plan*	Humana Plan CS150*	Humana Advantage Open Access	Aflac
Codes	Sample Procedures	Copay / Fee Schedule			Aflac Pays
Examinations					
9430	Consultation/Office Visit	\$10	\$5	\$0	\$30
0120	Periodic Oral exam & diagnosis	\$0	\$0	\$0	\$30
X-Rays					
0272	Bitewings 2 films	\$0	\$0	\$0	\$15
0210	Complete Series	\$5	\$0	\$0	\$15
Preventative Care					
1110	Complete Prophylaxis (adult)	\$5	\$0	\$0	\$30
1510	Space maintainer	\$70 + Lab	\$45 + Lab	\$137	\$95
Restorative					
2140	Amalgam-one surface	\$20	\$0	\$19	\$55
2150	Amalgam-two surfaces	\$25	\$0	\$25	\$60
2330	Resin-one surface, anterior	\$45	\$35	\$21	\$70
Endodontics					
3310	Anterior tooth (Excludes Final Restoration)	\$155	\$100	\$271	\$175
3330	Molar Tooth	\$275	\$250	\$428	\$230
Periodontics					
4210	Gingivectomy/ gingivoplasty (per quadrant)	\$150	\$125	\$278	\$150
4260	Osseous surgery (per quadrant)	\$425	\$350	\$529	\$150
Prosthodontics					
5110	Complete Upper Denture	\$325 + Lab	\$300 + Lab	\$498	\$405
5120	Complete Lower Denture	\$410 + Lab	\$300 + Lab	\$498	\$405
Fixed Crown & Bridge					
6240	Bridge pontic-porcelain fused to high noble metal/unit	\$280 + Lab	\$280 + Lab	\$373	\$290
6750	Crown-porcelain fused to high noble metal/unit	\$280 + Lab	\$280 + Lab	\$426	\$290
Oral Surgery					
7140	Extraction single tooth	\$20	\$0	\$58	\$45
7220	Extraction-soft tissue impaction	\$75	\$50	\$114	\$100
7240	Extraction-full bony impaction	\$140	\$85	\$177	\$150
Orthodontics***					
8080	Orthodontics - Child (24 months)	25% discount	\$1,800	\$2,100	
8090	Orthodontics - Adult (24 months)	25% discount	\$2,000	\$2,300	

PPO / Traditional Summary of Benefits	Humana Elite Preferred Plan 510	
Benefit Schedule	In Network	Out of Network**
Annual Deductible		
Per Person	\$50	\$50
Family Maximum	\$150	\$150
Waived for Preventative?	Yes	Yes
Benefit Level		
Preventative	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia *** (24 months)	50%	50%
Maximum Benefit		
Annual Benefit Maximum	\$1,000	\$1,000
Orthodontia Annual Maximum	\$500	\$500
Orthodontia Lifetime Maximum	\$1,000	\$1,000
Out-of-Network Benefits		
Payable Level	N/A	70th Percentile
Major Services	12 months	
Benefit Classification:		
Endodontics	Basic	Basic
Periodontics	Basic	Basic

** Out-of-Network Balance Billing is the difference between the "allowed amount" an insurance company will pay to an in-network provider and the higher amount that an out-of-network provider charges you. Balance Billing is in addition to your deductible and coinsurance and is your responsibility (not covered by your plan).

*** Treatment extending over 24 months is not covered and will be charged at the provider's reasonable and customary rates.

* Members must select a participating dentist from the provider listing and notify the carrier of your selection in order for benefits to be payable.



Vision Insurance: HumanaVision Care Plan

Humana

Customer Service: (800) 865-3676

www.compbenefits.com

The City offers vision insurance through Humana’s CompBenefits. A brief description of the HumanaVision Care plan and summary of benefits is provided below. Vision insurance is 100% employee paid and semi-monthly premiums are deducted from your paycheck 24 times a year. The employee costs per pay period are shown on the premium table to the right. For detailed coverages, exclusions and stipulations, please refer to the carrier’s benefit summary or contact Humana’s Customer Service.

In-Network Benefits

The vision plan offers you and your covered dependents coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered members can select any optometrist or ophthalmologist that participates in the **HumanaVision Care Network**. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan’s schedule of benefits. Cosmetic services and optional upgrades are available at an additional wholesale cost. There is no Calendar Year Deductible or Out-of-Pocket Maximum, however, there are benefit reimbursement maximums for certain services per calendar year.

How to Locate a Provider

To search for a participating provider please contact Humana’s Customer Service or visit www.compbenefits.com. Under the “Providers/Search” tab, select “Find Vision Providers.” Then, choose “**VisionCare Plan**” as your plan type, complete the additional search criteria and click “Search.”

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

Vision Insurance – HumanaVision Care Plan Employee 2016 Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	\$2.96
Employee + One Dependent	\$5.92
Employee + Family	\$7.91

Vision Insurance – HumanaVision Care Plan 2016 Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	\$5.92
Retiree + One Dependent	\$11.84
Retiree + Family	\$15.82

Services	In Network
Eye Exam	\$10 copay (once every 12 months)
Lenses (single, bifocal, trifocal)	\$15 copay (once every 12 months)
Frames	\$90 credit on retail (once every 24 months) \$45 credit on wholesale price (once every 24 months)
Contact Lenses Non-elective (Medically Necessary)*	100% after \$15 copay (once every 12 months)
Contact Lenses Elective (Fitting, Follow-up & Lenses)*	Up to \$105 Allowance (once every 12 months)

Contact Humana’s Customer Service for an out-of-network reimbursement schedule.

*Contact lenses are in lieu of lenses/frames. Medically necessary contact lenses require prior authorization.

Contact: Human Resources
Phone: (727) 562-4870

The City provides each benefit eligible employee with life insurance in the following amounts at no cost to the employee:

- CWA – One and one-half times your annual base salary up to a maximum of a \$50,000 benefit
- FOP and IAFF – \$2,500 benefit
- SAMP – \$2,500 benefit plus one times your annual base salary
 - SAMP employees also have the ability to purchase additional coverage in increments of \$50,000 up to a maximum of 5 times annual salary or \$500,000. Newly hired or newly eligible SAMP employees can elect up to \$150,000 coverage without submission of Evidence of Insurability for up to 31 days following their initial date of eligibility. Any election of life insurance more than 31 days after the date of initial eligibility and/or the election of any amount exceeding \$150,000 will require the submission of Evidence of Insurability and approval by the carrier.

Contact Human Resources for plan details and premium rates.



Voluntary Supplemental Insurance: Aflac Individual Plans

Aflac
Agent: Frank D’Ascoli
Phone: (727) 514-7977
email: Frank.DAscoli@verizon.net

The City offers a variety of supplemental insurance plans through Aflac. Aflac plans may be purchased separately on a voluntary basis and premiums payroll deducted. Aflac pays money directly to you, regardless of what other insurance plans you may have. A description of each available plan and bi-weekly premium rates have been provided below. To learn more about these Aflac plans and/or schedule a personal appointment, contact the City’s Aflac Agent, Frank D’Ascoli, at (727) 514-7977.

Aflac Individual Accident Plan			
Covers on-the-job and off-the-job injuries due to accidents for the employee and covered family members. Since this plan is an individual policy you can keep your current accident plan and add this individual policy (or) you can replace your current accident plan. However; if you drop your individual accident plan, you will not be able to enroll in it again as it is no longer available for sale			
Clerical employees not involved in labor. 80% office.			
Employee	\$9.69	One Parent Family	\$15.67
Employee & Spouse	\$13.65	Two Parent Family	\$19.63

Hospital Advantage Plan				
Aflac will pay a hospital confinement benefit of \$2,000 when a covered person is confined for 23 hours or more. \$2,000 benefit will be paid if hospital confinement occurs 90 days from the previous confinement. No Lifetime Maximum. Benefits also include \$25 physician visit reimbursements, Diagnostic Imaging, in-patient and out-patient surgery and daily hospital confinement. See policy brochure for details.				
	Option 1	Option 1 & 2	Option 1, 2 & 3	Option 1, 2, 3 & 4
Individual	\$28.41	\$32.37	\$36.08	\$40.89
One Parent Family	\$36.40	\$43.81	\$47.97	\$53.04
Employee & Spouse	\$43.68	\$51.94	\$58.70	\$67.63
Two Parent Family	\$45.96	\$55.64	\$62.27	\$69.42



Voluntary Supplemental Insurance: Aflac Individual Plans *(Continued)*

Cancer Care Plan

Although medical insurance is usually adequate for most illnesses, it cannot always withstand the financial burden cancer can impose on you and your family.

Individual: \$14.04	One Parent Family: \$14.04	Employee & Spouse \$25.42	Two Parent Family: \$25.42
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Critical Care and Recovery Plan

Level I with \$500 Annual Building Benefit Rider - Medical science and early, fast detection have increased survival rates for many serious medical conditions. Aflac provides the financial assistance to help you get back on your feet if you are faced with expensive treatment and loss of income for any of the specified health events listed.

Ages	Individual	One Parent Family	Employee + Spouse	Two Parent Family
18 - 35	\$5.72	\$6.31	\$8.84	\$9.95
36 - 45	\$9.23	\$9.62	\$15.15	\$16.38
46 - 55	\$12.35	\$12.74	\$21.32	\$22.82
56 - 70	\$16.06	\$16.51	\$29.45	\$31.20

Short Term Disability

Guaranteed Issue Benefits. Provides coverage for disabilities resulting from a covered sickness or off-the-job injury. 3-month Disability Benefit Period. 7-day Elimination Period. Benefits payable when policyholder's earnings are less than 80% of pre-disability salary.

Annual Income	\$17,000	\$22,000	\$24,000	\$26,000	\$27,000	\$29,000	\$32,000	\$34,000	\$36,000	\$38,000	\$39,000	
Monthly Benefit	\$1,000	\$1,100	\$1,200	\$1,300	\$1,400	\$1,500	\$1,600	\$1,700	\$1,800	\$1,900	\$2,000	
Age	18-64	\$11.05	\$12.16	\$13.26	\$14.37	\$15.47	\$16.58	\$17.68	\$18.79	\$19.89	\$21.00	\$22.10
	65-74	\$13.65	\$15.02	\$16.38	\$17.75	\$19.11	\$20.48	\$21.84	\$23.21	\$24.57	\$25.94	\$27.30

Aflac Dental Plan

Aflac's dental plan supplements your current dental plan by providing cash benefits directly to you for dental services. There is no network however; waiting periods may apply depending on services needed. Policy annual maximum \$1,400 per covered person. See page 12 for benefits.

Individual: \$11.64	One Parent Family: \$20.35	Employee & Spouse \$20.48	Two Parent Family: \$29.32
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Flexible Spending Accounts

Administered by: WageWorks/Aflac
 Agent: Frank D'Ascoli
 Phone: (727) 514-7977
 Fax forms to: (877) 353-9256
www.takecarewageworks.com

If you have predictable healthcare expenses for yourself or your family, such as deductibles and copays, or any work-related day care expenses, the City of Clearwater offers Flexible Spending Accounts (FSA) administered through Aflac by WageWorks. FSA allow you to redirect a portion of your salary to pay for unreimbursed medical and dependent care expenses you may incur. The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA. During the year, you have access to this account for reimbursement of some expenses that are not covered by insurance. An FSA not only results in a substantial tax savings, it also increases your spending power. There are two types of FSAs:

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

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

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

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

FSA Guidelines

- You must make a new election in BenTek each year.
- You may carry over up to \$500 of unused funds from your Healthcare Reimbursement Account into the next plan year after a plan year ends and all claims have been filed. Dependent Care funds CANNOT be carried over.
- After a plan year ends and all claims have been filed any unused funds cannot be returned to you or carried forward to the next plan year, with the exception of the \$500 carry over that may be allowed for the Healthcare Reimbursement Account.
- You can enroll in either or both FSAs during open enrollment period, a qualifying event, or new hire eligibility only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- You have a run out extension at the end of the plan year (90 days) to claim reimbursement for eligible expenses incurred during your period of coverage within the plan year (January 1st - December 31st).
- Domestic Partners are not eligible, as federal law does not recognize them as qualified dependents.
- **Irrevocable Election Rule: IRS rules prohibit the modification and/or revocation of elections before the beginning of the next plan year unless there is a qualifying change in status (i.e., change in marital status, employment status, work schedule, number of tax dependents, dependents' eligibility or worksite, or as otherwise defined by the IRS). The change must be a result of and correspond with the change in status (as determined by your employer/plan administrator)**

Here's How It Works

An Employee earning \$30,000 elects to place \$1,000 into an FSA Health Care Savings Account, with payroll deductions amounting to \$41.66 based on a 24 pay schedule. Health care expenses can then be paid with tax-free dollars from the account; resulting in a tax savings of \$165 for the employee.

	With FSA	Without FSA
Salary	\$30,000	\$30,000
FSA Pre-Tax Contribution	- \$1,000	- \$0
Taxable Pay	\$29,000	\$30,000
Estimated Tax (16.45% = 15% Payroll + 1.45% Medicare)	- \$4,770	- \$4,935
Unreimbursed After-Tax Expenses	- \$0	- \$1,000
Spendable Income	\$24,230	\$24,065
Tax Savings	\$165	

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

Debit Card

Employees who are electing an FSA for the first time will be provided with a debit card pre-loaded with the dollar amount available. Employees who currently have a debit card from the prior year can keep their card and new elections will be pre-loaded for 2016. If you do not still have your debit card from 2015, you can request a new one online through the EBC. Your elected amount will continue to be deducted semi-monthly from your paycheck just as it is now, but there will be no need for submitting paperwork to receive reimbursements. Just present your debit card to pay for FSA eligible expenses. Most eligible services or items are automatically tabulated as FSA qualified when you use your debit card. As a reminder, over-the-counter items are no longer considered a qualified expense, unless prescribed by a physician. You can find a list of qualified and non-qualified expenses at <http://irs.gov/publications/p502/index.html>.

Filing a Claim

Some service providers may not have the ability to accept a debit card, so you may want to confirm with them beforehand. If a service provider does not accept the debit card, you may pay for the services and submit a paper claim for reimbursement to WageWorks, which will be administering the FSA benefits on behalf of Aflac. Paper claim forms may be obtained from Human Resources, on the City Intranet or the online Employee Benefits Center, or directly from the Wameworks website at www.takecarewageworks.com, where you can also view the status of your account at any time. Documentation may also be required for some claims. Please maintain all receipts for FSA related services for the entire plan year.

COBRA Continuation of Medical Coverage Benefits

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

Medicare D Creditable Coverage

Clearwater’s prescription drug coverages are considered Creditable Coverage under Medicare Part D. If you or your dependents are or will be eligible for Medicare, you may obtain more information by requesting a Medicare D Disclosure of Creditable Coverage Notice.

Notice of Privacy Practice of City of Clearwater

The Privacy Notice of the City is available and you can obtain a copy by contacting Human Resources.

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

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end.

An employee, spouse/domestic partner of an employee or a dependent child of an employee covered by the City’s group health plan has the right to choose this continuation coverage when coverage is lost for any of the reasons provided below:

Employee:	<ol style="list-style-type: none"> 1) Reduction in hours of employment (that disqualifies group insurance participation eligibility); or 2) Termination of employment (for reasons other than gross misconduct).
Spouse/Domestic Partner of an Employee:	<ol style="list-style-type: none"> 1) The death of your spouse/domestic partner; or 2) A termination of your spouse’s/domestic partner’s employment (for reasons other than gross misconduct) or a reduction in your spouse’s hours of employment; or 3) Divorce or legal separation from your spouse/domestic partner; or 4) Your spouse/domestic partner becomes entitled to Medicare.
Dependent Child of an Employee:	<ol style="list-style-type: none"> 1) The death of a parent; or 2) A termination of the parent’s employment (for reasons other than gross misconduct) or a reduction in the parent’s hours of employment with the City; or 3) Parent’s divorce or legal separation; or 4) A parent becomes entitled to Medicare; or 5) The dependent child ceases to be a “dependent child” under the City’s group health plan.

COBRA - Continuation of Group, Medical, Dental and Vision Insurance, Under the City's Employee Benefit Plans

Do I Have to Notify the City of Any Qualifying Events Under COBRA?

Employees or their families must notify the City within 60 days of the date coverage would otherwise terminate in the event of a divorce, legal separation, or when a child no longer qualifies as a covered dependent under the plan. Individuals failing to notify the Human Resources Department of these events within the 60-day period will not be permitted to continue coverage.

How Long Can I Continue Coverage?

In general, you can continue coverage for up to 18 or 36 months, depending on the qualifying event. If the qualifying event is employment termination or reduction in hours, the maximum period of time you can continue coverage is 18 months from the date of the qualifying event. For other qualifying events, the maximum period is 36 months. If a second qualifying event occurs, the maximum coverage period will be extended from 18 months to 36 months, measured from the date of the first qualifying event.

Can the City Terminate My Continuation Coverage Before the Maximum Coverage Period Ends?

The City can terminate a person's continuation coverage before the maximum coverage period ends for any of the following reasons:

- Payment for the person's coverage is not received on a timely basis;
- The person becomes covered by another group health plan maintained by another employer that does not limit or exclude coverage for any preexisting medical condition of the person;
- The person becomes covered by Medicare (except a person covered by Medicare because of end stage renal disease or because the person is a disabled active individual); and/or
- The City ceases to provide group health plan coverage for all active employees.

Do I Have to Pay for My Continuation Coverage?

You must pay the full cost of continuation coverage plus 2% for the City's administrative costs. The information on the cost of continuation coverage and the payment terms will be included in notices to individuals who have a qualifying event.

May I Obtain Conversion Coverage When My Continuation Coverage Terminates?

When continuation coverage terminates, you can purchase an individual medical policy without proof of insurability. This conversion privilege is also available if you decline continuation coverage.

Who Can I Contact If I Have Questions About Continuation Coverage?

If you have any questions about continuation coverage, please contact the Human Resources Department at 562-4870.

Can I Have More Than One Qualifying Event?

Sometimes, a spouse or dependent child can have more than one qualifying event. A second qualifying event occurs if these three conditions are met:

- The first event is the employee's employment termination or reduction in hours;
- The second event gives rise to 36 months of continuation coverage (i.e., a covered employee's death or divorce); &
- The second event takes place while continuation coverage was effective.

What Is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996. The Act is intended to provide protection from preexisting conditions limitations for employees and their dependents (qualified beneficiaries) when moving from job to job. Health plans now must provide qualified beneficiaries with proof or "certification" of the dates of their most recent period of "creditable coverage." This certification provides the qualified beneficiary proof of their coverage from the receiving plan. Certificates are provided to qualified beneficiaries losing coverage at the following times:

- When the qualified beneficiary loses coverage – whether or not coverage continues under COBRA;
- When the individual loses coverage under COBRA; and/or
- Upon request within 24 months of the loss of coverage.



Retirement Benefit Summary

The City of Clearwater allows employees upon retiring to continue almost all benefits. Retirees that elect to continue City benefits will have premiums paid as an after-tax deduction from their pension benefit. Retirees will be responsible for the full monthly premium cost for each benefit continued; the City does not subsidize any portion of benefits for retirees. Upon retiring, if the retiree opts out of coverage, he/she will no longer be eligible to participate in the City's plans.

Retirees will not be able to continue flexible spending accounts (which may be continued through COBRA) and the life insurance (which may be continued through direct payment to the provider).



Disability Retirement Benefit

The City allows retirees to apply for non-work related disability benefit. This benefit matches the active employee disability benefit but is only available upon retirement if the employee has completed at least 10 years of pensionable service.

Retirees will also be allowed to apply for work related disability benefit. This benefit will either match the active employee disability benefit or a minimum percentage of the final monthly compensation (42% for Non-Hazardous Duty or 66 2/3% for Grandfathered and Hazardous Duty participants) whichever is greater, as long as they are participating in the plan.



Pension Benefits

The City of Clearwater Employees' Pension Plan is an IRS-qualified, defined benefit plan, self-administered by the City of Clearwater and created for the sole purpose of providing retirement benefits to its participants. The contribution and benefit will depend on an employee's job classification and participation date, prior to retiring.

Please Note: The reference "Grandfathered" is defined as an employee who was eligible for normal retirement and contributing to the pension prior to the ordinance changes on 1/1/13.

How much of my own earnings do I contribute to the pension?

- Grandfathered - Participants contribute 8% of pensionable earnings, including special pays and overtime.
- Non-Hazardous Duty - Participants contribute 8% of base compensation.
- Hazardous Duty - Participants contribute 10% of pensionable earnings, including special pays and overtime (up to 300 hours per calendar year).

The City contributes an amount determined annually by the plan actuary based on the plan's performance. Not less than 7% of basic compensation for all employees participating. Also, all deductions are on a pre-tax basis. Employees participating in the pension plan do not contribute to Social Security (OASDI) during that time; although most do have Medicare (HI) taxes deducted.

Participants may opt to elect other forms of retirement, each of which will be calculated at the actuarial equivalent of the normal form based on the biographical data of the participant and the beneficiary.

- **Joint and Survivor Annuity** - An annuity paid monthly for the life of the participant. Upon death, 100% paid to the surviving spouse, and if none, the surviving children under the age of 18, for a period of five years, after which time the benefit is reduced by 50% for the life of the beneficiary or until the spouse remarries or the child reaches the age of 18, whichever comes first. *(Non-Hazardous Duty employees, if you are not Grandfathered, this option is not available).*
- **Single Life Annuity** - An annuity paid monthly for the life of the participant.
- **10-Year Certain and Life Annuity** - An annuity paid monthly for the life of the participant with 120 payments guaranteed.
- **50, 75, 100 or 66 2/3% Joint and Survivor Annuity** - An annuity paid monthly for the life of the participant. Upon death, 50%, 75%, 100% or 66 2/3% is paid to the surviving beneficiary for life.

In addition to the above options, a **Partial Lump Sum** option is available. This allows retirees to receive 10%, 20% or 30% of their normal retirement benefit as a one-time lump sum payment received in the first pension benefit payment, with the monthly benefits reduced accordingly thereafter. This lump sum amount is eligible for rollover.

When can I retire on pension?

- **Grandfathered** – Participants must either complete 30 years of pensionable service, 20 years of service and be at least age 55 or 10 years of service and be at least age 65.
- **Non-Hazardous Duty** - Participants must either complete 25 years of pensionable service and be at least age 60 or complete 10 years of pensionable service and be at least age 65.
- **Hazardous Duty** - Participants must either complete 20 years of pensionable service or complete ten years of pensionable service and be at least age 55. *(There is an early retirement option for Hazardous Duty participants, which pays as early as age 50 after ten years of pensionable service, with a 3% reduction for each year below the age of 55).*

How is my retirement benefit calculated?

- For Grandfathered and all Hazardous Duty participants, the normal monthly benefit formula is: 2.75% multiplied by the number of years of credited service multiplied by final monthly compensation.

Example:	
Final Avg. Compensation	\$43,200
X Pension Factor	0.275
X Credited Service	25
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Annual benefit	\$29,700
Monthly Benefit	\$2,475

- For Non-Hazardous Duty participants, the normal monthly benefit formula is: 2% multiplied by the number of years of credited service multiplied by final monthly compensation.

Example:	
Final Avg. Compensation	\$43,200
X Pension Factor	0.2
X Credited Service	25
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Annual benefit	\$21,600
Monthly Benefit	\$1,800

What if I leave the City of Clearwater before I am eligible to retire?

- If you have completed at least ten years of pensionable service, you may vest your interest in the plan and begin to collect a retirement benefit when you would otherwise have been eligible, while working for the City of Clearwater.
- If you have less than ten years of pensionable service or do not wish to vest, you may elect to receive a refund of your contributions to the plan plus 5% simple interest.

What if I pass away as an active employee?

- If you have a named beneficiary on file, that person will be able to select either a refund of employee contributions or a monthly retirement benefit, depending on his/her preference and whether or not you completed at least ten years pensionable service.
- If there is no beneficiary on file, a refund of contributions will be paid to your estate unless you are married or have minor children at the time of death, in which case they may receive a limited benefit.

What are the rules regarding a beneficiary to my pension benefit?

- Participants are encouraged to elect a beneficiary to be kept on file in the event of pre-retirement death. Until retirement, participants may elect to change the beneficiary at any time.
- After retirement, the beneficiary may be changed twice, depending on the option selected, which will result in a recalculation of the monthly benefit amount.
- Only one beneficiary may be named at a time.

For more information regarding your retirement benefits and options available, you can visit the City intranet site and view the City Code of Ordinances which describes, in detail, the provisions of the retirement plans. You may also contact Jennifer Moulton, the Senior Pension Payroll Analyst, at (727) 562-4523 or Jennifer.Moulton@MyClearwater.com with additional questions, request an estimate or to make an appointment to complete retirement paperwork.



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