



RETIREE BENEFIT GUIDE

January 1, 2026 through December 31, 2026

This document is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the “plan documentation”) for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual’s rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

INTRODUCTION

The City of Sarasota provides a comprehensive compensation package including group insurance benefits. The Benefit Guide provides a general summary of these benefit options as a convenient reference. Please refer to the City's Personnel Policies, applicable Union Contracts and/or Certificates of Coverage for detailed descriptions of all available retiree benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources using the contact information provided. Information and descriptions provided are for the specific plan year and should not be construed as a contract.

Important Notices for Plan Participants & Beneficiaries

The Federal Government has outlined several notices as Important Notices for our medical plan participants:

- Children's Health Insurance Program Reauthorization Act (CHIP)
- HIPAA Notice of Privacy Practices
- Medicare Part D Creditable Coverage Notice
- Summary of Benefits and Coverage
- Women's Health and Cancer Rights Act of 1998
- Health Insurance Marketplace Coverage Notice

All of the above notices can be viewed in their entirety on the employee benefits website at sarasotafl.gov/Department-Pages/Human-Resources/Benefits-and-Compensation

Complete, printed copies can also be mailed direct to your home. Please send requests to: Human Resources, 1565 1ST Street, Annex Building, 3rd Floor, Sarasota, FL 34236 or call **(941) 263-6338**.

Eligibility Guidelines

The City's benefit plan is January 1st to December 31st

Retiree Eligibility

- Retiree's coverage will be effective the date of retirement.

Dependent Eligibility

A dependent is defined as the participant's legal spouse or domestic partner and dependent child(ren) of the participant or domestic partner. Dependent children may be covered through the end of the calendar year in which the child reaches age 26 with no eligibility requirements. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A child placed for adoption
- A stepchild
- A foster child
- Newborn dependent of a dependent up to 18 months (applies to medical only)

Over-age Dependents may be covered by the medical and dental plans through the end of the calendar year in which the child turns age 26.

Medical and dental coverage may continue to the end of the calendar year in which the dependent reaches the age of 30, if the dependent is:

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

Disabled Dependents

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

- Physically or mentally disabled and incapable of self-sustaining employment by reason of mental disability or physical handicap; AND
- Coverage began prior to the age of 19; AND
- Dependent has been continuously insured.

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

Domestic Partner

Domestic Partners may be eligible to participate in the City's group medical insurance plans and will be required to complete a Declaration of Domestic Partnership that **must be completed in the Human Resources Department**. The IRS guidelines state that a retiree may not receive a tax advantage on any portion of premium paid related to domestic partner coverage. Retirees insuring domestic partners and/or child dependents of a domestic partner are required to pay "imputed income tax" on premium deductions and should consult their tax expert. **The establishment of a Domestic Partnership is not a Qualifying Event under Section 125 of the Internal Revenue Code.** Please contact Human Resources for more information.

Qualifying Events and IRS Code Section 125

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

Qualified Life Events include, but are not limited to:

- You get married or divorced
- You have a child, gain legal custody or adopt a child
- Your spouse and/or other dependent(s) passes away
- An increase or decrease in your work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- 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).

Please note: The forming of a Domestic Partnership, in and of itself, is not considered a qualifying event per IRS Code, Section 125.

HR requires appropriate documentation for each Qualifying Event.

The City reserves the right to modify, revoke, suspend, terminate or change the program, in whole or in parts, at any time. This is a Benefits Highlight Summary and not a contract. All benefits are subject to the provisions and exclusions under the master contract.

HOW TO ENROLL IN BENEFITS

Retirees can manage their Benefit elections within Workday. You can initiate a Benefit Change when you have a qualifying life event. Here are some instructions to get you started. Don't hesitate to reach out to Benefits in HR for more detailed instructions if needed.



Initiating the Change Benefit Event

www.myworkday.com/sarasotagov/login.html

Qualifying Life Events

1. Navigate to Benefits and Pay App
2. Click Benefits
3. Click Change Benefits
4. Select Qualifying Life Event
 - a) Enter the date the event occurred
 - b) Upload attachment for proof of event
5. In your My Tasks, you will have the Benefit Change item to get started





Making the Change

Once you start the process, and answer the initial questions, you will be taken to the benefit election home page. Click on each item to see more information and make your selections.

Health Care

 Medical-Retiree Waived <hr/> Enroll	 Dental-Retiree Waived <hr/> Enroll	 Vision-Retiree Waived <hr/> Enroll
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Insurance

 Basic Life & AD&D The Standard - Retiree (Employee) Cost (Monthly) Included Coverage \$3,000 <hr/> Manage	 Voluntary Employee Life Waived <hr/> View	 Voluntary Spouse Life Waived <hr/> View	 Voluntary Child Life Waived <hr/> View
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[Review and Sign](#)

HEALTH CENTER

The Sarasota Health Center is available to retirees and their dependents 6 years and older enrolled in the City’s medical insurance plan. It is completely voluntary and private so you can be sure that your medical information will not be shared with your employer. The Sarasota Health Center can serve you in several ways to help lower your out-of-pocket costs and improve your health. The Sarasota Health Center provides the care you and your family need for all non-emergency illnesses.

For those enrolled in Plan 2– HSA, there will be a \$5 charge per visit. There is no charge for preventive visits, such as the wellness biometric screening and annual wellness physical. Lab orders and referrals for imaging will also continue to be at no cost.

The clinic provides services such as:

- Primary Care
- Well Woman Visits
- Prescription dispensing
- Labs performed on-site
- ECG’s
- Health Risk Assessments
- Health Coaches

To schedule an appointment call (941) 893-2556 or visit www.marathon-health.com/mobile/.

The clinic is located at 237 Payne Parkway, Unit 101 Sarasota, Florida 34237

Hours of Operation				
Monday	Tuesday	Wednesday	Thursday	Friday
6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)

Download the Marathon Health Mobile App Today!

The Marathon Health Mobile App empowers you to take charge of your health.

Features include:

- Easy Sign-in and sign up
- Schedule and manage appointments
- Message your care team
- Review your profile information

Message your care team or schedule appointments with ease, and so much more by using the Marathon Health mobile app! Simply scan the below QR code with your phone’s camera, click the link and this will bring you directly to where you can download the app! Additionally, you can head to the Apple App Store, or Android’s Google Play to manually search and download the App!



Scan this QR code with your smartphone’s camera to download the Marathon Health app

BLUE CROSS BLUE SHIELD MEDICAL INSURANCE

The City provides coverage, administered by Blue Cross Blue Shield, for eligible retirees and their dependents. The costs per pay period for coverage are listed in the premium table below. **For information about your medical plan, please refer to the Summary of Benefits and Coverage (SBC) on our website at sarasotafl.gov/Department-Pages/Human-Resources/Benefits-and-Compensation**

Plan 1 - HRA

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly *
Retiree Only	\$158.28	\$898.42
Retiree + One	\$710.89	\$1,792.26
Retiree + Family	\$1,271.45	\$3,133.02
Standalone Dependent (Not Medicare Eligible)	\$673.82	Not Applicable

Plan 2 - HDHP w/ HSA or HRA (Under 65 retirees eligible for HSA, over 65 retirees will have an HRA)

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly *
Retiree Only	\$0.00	\$786.70
Retiree + One	\$557.26	\$1,560.00
Retiree + Family	\$1,120.82	\$2,576.05
Standalone Dependent (Not Medicare Eligible)	\$590.03	Not Applicable

*The 2% COBRA administrator fee will be charged on the above rates.

2026 CITY OF SARASOTA MEDICAL PLAN 1 - HRA

FL AIt Network (PPO)	In Network	Out of Network**
Calendar Year Deductible (CYD)		
Individual	\$750	\$1,500
Individual + 1	\$1,500	\$3,000
3 or More Member Family	\$2,250	\$4,500
Deductible Type	Embedded	Embedded
Coinsurance***		
Plan Reimbursement	80%	60%
Member Responsibility	20%	40%
Out-of-Pocket Maximum (Includes Deductible, Coinsurance, & Copays)		
Individual	\$2,500	\$90,000
Individual + 1	\$5,000	\$90,000
3 or More Family	\$7,500	\$90,000
Out of Pocket Type	Embedded	Embedded
Teledoc Visit Copay		
Teledoc Visit Copay	\$20	N/A
Primary Care Physician*	\$20	40% After CYD
Specialists (No Referral Required)	\$35	40% After CYD
Acupuncture, Chiropractic, and Massage Therapy Visits (subject to maximums)	\$50	\$50
Preventative Services*	Covered 100%	40% After CYD
Emergency Room	\$250	\$250
Urgent Care Facility	\$75	\$75
Clinical Lab (Blood Work) at QUEST*	\$10	40% After CYD
X-Rays at Outpatient Facility*	\$10	40% After CYD
Advanced Imaging (MRI, PET, CAT, MRA) Outpatient Facility*	\$250 Per Scan	40% After CYD
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	40% After CYD
Mental Health/ Alcohol & Substance Abuse		
Office Visits: Mental Health & Alcohol & Substance Abuse	\$20 Copay (PCP), \$35 Copay (Spec.)	40% After CYD
Inpatient Hospital: Mental Health / Alcohol & Substance Abuse	20% After CYD / Covered 100%	40% After CYD / Covered 100%
Outpatient Facility: Mental Health / Alcohol & Substance Abuse	20% After CYD / Covered 100%	40% After CYD / Covered 100%
Prescription Drugs		
Deductible	N/A	Not Covered
RX Out of Pocket Maximum:		
Individual / Individual +1 / 3 or More Member Family	\$4,100 / \$5,700 / \$5,700	Not Covered
Tier 1: Generic	\$5	Not Covered
Tier 2: Preferred	40% of Cost, Min. \$35, Max. \$75	Not Covered
Tier 3: Non-Preferred	60% of Cost, Min. \$70, Max. \$100	Not Covered
Tier 4: Specialty	\$250	Not Covered
Mail-Order Rx (90-day supply)	3x Copay	Not Covered

*These services are provided at no cost when visiting the Sarasota Employee Health Center. SimonMed is available for conditions that are treated and managed within the Health Center and by the Health Center provider.

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

***CYD must be met before any co-insurance applies.

2026 CITY OF SARASOTA MEDICAL PLAN 2 - HSA

IRS rules prohibit those that are Medicare eligible (or those covering a Medicare eligible spouse) from contributing to a Health Savings Account (HSA) and therefore those Medicare eligible will have an HRA instead of an HSA with this plan.


FL Alt Network (PPO)	In Network	Out of Network**
Calendar Year Deductible (CYD)		
Individual	\$1,800	\$5,000
Individual + 1	\$3,400 Embedded Single, \$4,000 Max.	\$15,000
3 or More Member Family	\$3,400 Embedded Single, \$4,000 Max.	\$15,000
Deductible Type	Embedded	Embedded
Coinsurance***		
Plan Reimbursement	80%	60%
Member Responsibility	20%	40%
Out-of-Pocket Maximum (Includes Deductible, Coinsurance, & prescriptions)		
Individual	\$6,900	\$90,000
Individual + 1	\$6,900 Embedded Single, \$13,800 Max.	\$90,000
3 or More Family	\$6,900 Embedded Single, \$13,800 Max.	\$90,000
Out of Pocket Type	Embedded	Embedded
Teledoc Visit Copay		
Teledoc Visit Copay	20% After CYD	N/A
Primary Care Physician*	20% After CYD	40% After CYD
Specialists (No Referral Required)	20% After CYD	40% After CYD
Acupuncture, Chiropractic and Massage Therapy Visits (subject to maximums)	20% After In-Network CYD	20% After In-Network CYD
Preventative Services	Covered 100%	40% After CYD
Emergency Room	20% After In-Network CYD	20% After In-Network CYD
Urgent Care Facility	20% After In-Network CYD	20% After IN-Network CYD
Clinical Lab (Blood Work) at Quest*	20% After CYD	40% After CYD
X-Rays at Outpatient Facility*	20% After CYD	40% After CYD
Advanced imaging (MRI, PET, CAT, MRA) Outpatient Facility*	20% After CYD	40% After CYD
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	40% After CYD
Mental Health/ Alcohol & Substance Abuse		
Office Visits: Mental Health & Alcohol & Substance Abuse	20% After CYD	40% After CYD
Inpatient Hospital: Mental Health / Alcohol & Substance Abuse	20% After CYD / 100% Covered After CYD	40% After CYD / 100% Covered After CYD
Outpatient Facility: Mental Health / Alcohol & Substance Abuse	20% After CYD / 100% Covered After CYD	40% After CYD / 100% Covered After CYD
Prescription Drugs		
Deductible	Combined with Medical	Not Covered
Tier 1: Generic	20% After CYD	Not Covered
Tier 2: Preferred	20% After CYD	Not Covered
Tier 3: Non-Preferred	20% After CYD	Not Covered
Tier 4:Speciality	20% After CYD	Not Covered
Mail-Order RX	20% After CYD	Not covered

*These services are provided for a \$5 cost when visiting the Sarasota Employee Health Center. SimonMed is available for conditions that are treated and managed within the Health Center and by the Health Center provider.

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

***CYD must be met before any co-insurance applies.

THINGS TO CONSIDER WHEN CHOOSING A HEALTH PLAN



Here are a few things to think about when deciding which health plan is right for you and your family.

Think about your doctors visits over the past year.

- ◆ Do you think you'll see the doctor more or less this year?
- ◆ How did your insurance work during your last appointment?
- ◆ Do you want a similar insurance plan this year?

Make a list of the prescription medications you're taking. If prescription drug coverage is part of your medical plan, you can look up the name of your prescriptions through your health plan's drug list to determine if they're covered.

What's most important to your budget?

How much cost variation are you comfortable with? Plans that have copays built in, like preferred provider organization (PPO) plans, typically cost more each month in premium, but less in coinsurance when you visit the doctor. High deductible plans typically cost less each month in premium, but your costs will vary when visiting the doctor or filling a prescription.

Be aware of what's not included in your plan.

Make sure you're familiar with the provider network for your plan and any excluded services.

Are you expecting any big changes in the coming year?

Is there a medical procedure you or a family member may need in the coming months?

Do you plan on expanding your family? There are qualifying life events, like marriage or having a baby, that allow you to add dependents to your plan during the benefits year. Make sure you know how your plan costs may change in those scenarios.

Remember, you're committed to your health plan selection until the next open enrollment opportunity unless you have a qualifying event.

Qualifying events include:

- ◆ Marriage, divorce or legal separation.
- ◆ When you or a dependent gets other coverage.
- ◆ Death of a spouse or dependent.
- ◆ Birth or adoption of a child.
- ◆ Enrollment in Medicare or Medicaid.

For information about your eligibility and benefits, log in to [My Health Toolkit®](#) and select [My Plan & Benefits](#). Next, select [Health](#), then [Health Benefits](#). On the My Health Toolkit app, select [Benefits](#), then [Health Benefits](#). In this section, you can see your benefits at a glance, including the type of coverage you have and where you stand with your maximum out of pocket and deductible. You also can look up specific types of coverage such as hospital inpatient, surgery, urgent care and office visit. For questions about your deductible or out-of-pocket maximum amounts, please use the [Ask Customer Service](#) button on the Benefits page.

MAKE THE MOST OF YOUR BENEFITS

Health issues are in the news more than ever. It's a good thing you have access to top-quality care from the largest provider network in the nation.

Please use this guide to make the most of your benefits. We appreciate having you as a member and will do all we can to serve you.

For your health,
Blue Cross and Blue Shield of Florida, Inc.



These topics are included in this guide:



Using your member ID card



Finding doctors and cost details on our website



Discounts on health products and services



Connecting in ways that work for you — including texts, phone calls, emails, web inquiries and our app



Tips on the benefits available with your health plan — including telehealth, if applicable

Symbols in this guide:



Log in to your **My Health Toolkit®** account.



Call the number on the back of your membership ID card to speak to a **customer service advocate**.

WE'VE GOT YOU COVERED WITH YOUR MEMBERSHIP CARD

Your BCBSF membership card contains important information that helps providers apply your benefits correctly. Keep it with you at all times or download a digital ID card to keep on your smartphone. A health care provider usually will ask to see your insurance card at the beginning of your visit.

Covered family members also can use the subscriber's card, or you can forward them their own digital copy of it.

Your member ID contains a set of letters and numbers that are unique to you.

Visit our main website for additional information and to log in to your My Health Toolkit account.

SUBSCRIBER'S FIRST NAME	
SUBSCRIBER'S LAST NAME	
Member ID XXX123456789012	
TIER 1 DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX
TIER 2 DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX
IN NETWORK DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX
OUT OF NETWORK DEDUCTIBLE	\$XX,XXX
OUT OF POCKET	\$XX,XXX
MyHealthToolkitFL.com	
NetworkBlue SM PPO [®]	



Convenient option: your digital ID

It's all about convenience! Your digital ID card has the same information as the card you receive in the mail, but you can:

- ◆ View the digital ID on a smartphone, tablet or computer.
- ◆ Email the card to a spouse, child, doctor's office or pharmacy.
- ◆ Print the card from a smartphone, tablet or computer and use the printout just like a plastic card.

Accessing your digital ID

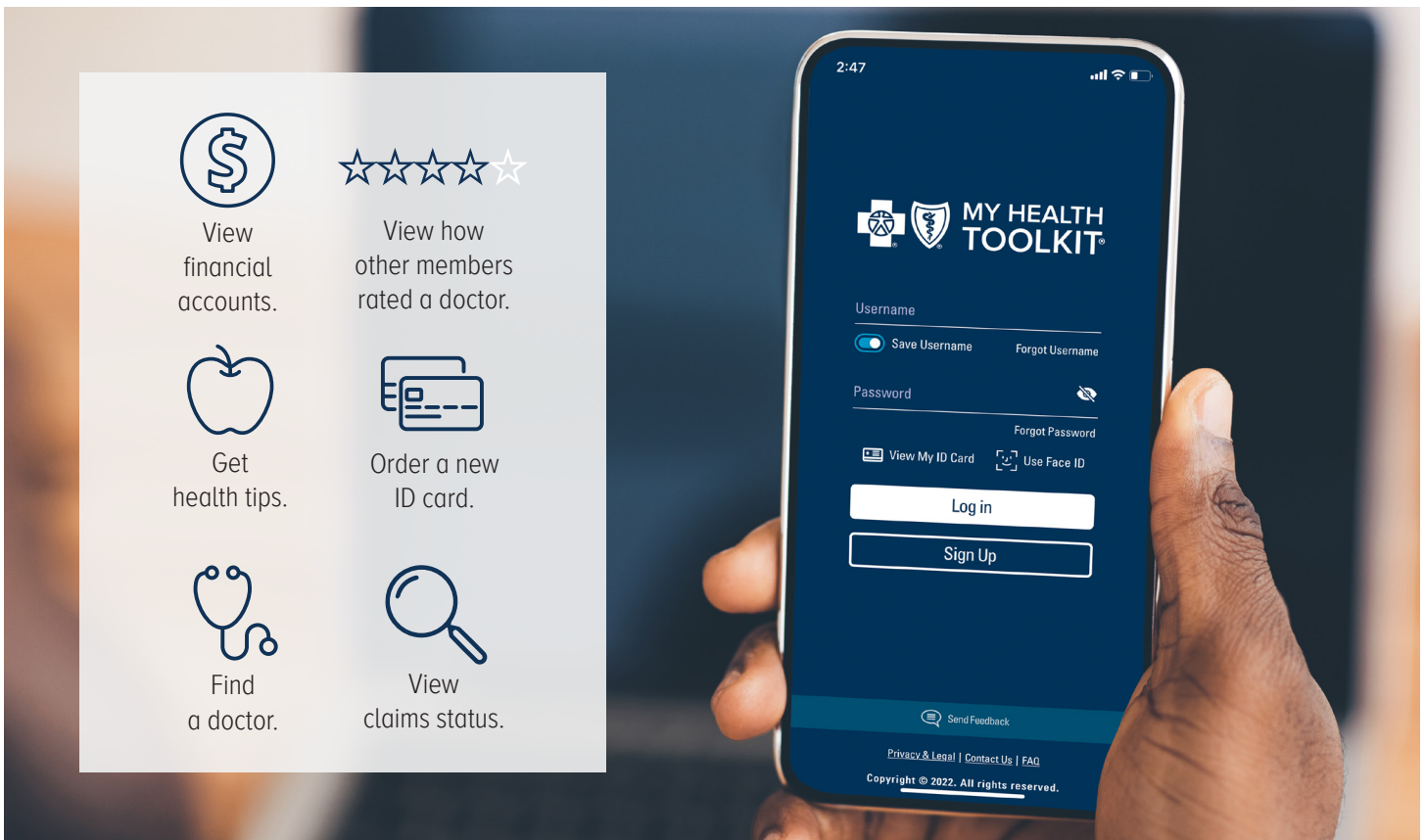
- ◆ From a computer or mobile device, log in to [My Health Toolkit](#).
- ◆ Follow the prompts to select/view your insurance ID card.

TRY THIS SHORTCUT

Get easy access to your benefits information by downloading the My Health Toolkit® mobile app today! It's free on the App Store or Google Play.



Register quickly through the app using your birth date plus your member ID number or Social Security number. Or just log in if you're already a My Health Toolkit user.



Your account homepage will link you to all of the helpful resources included with your health benefits plan.

Now you have anywhere, anytime access to your benefits information, including claims, discounts and how you prefer to be contacted.

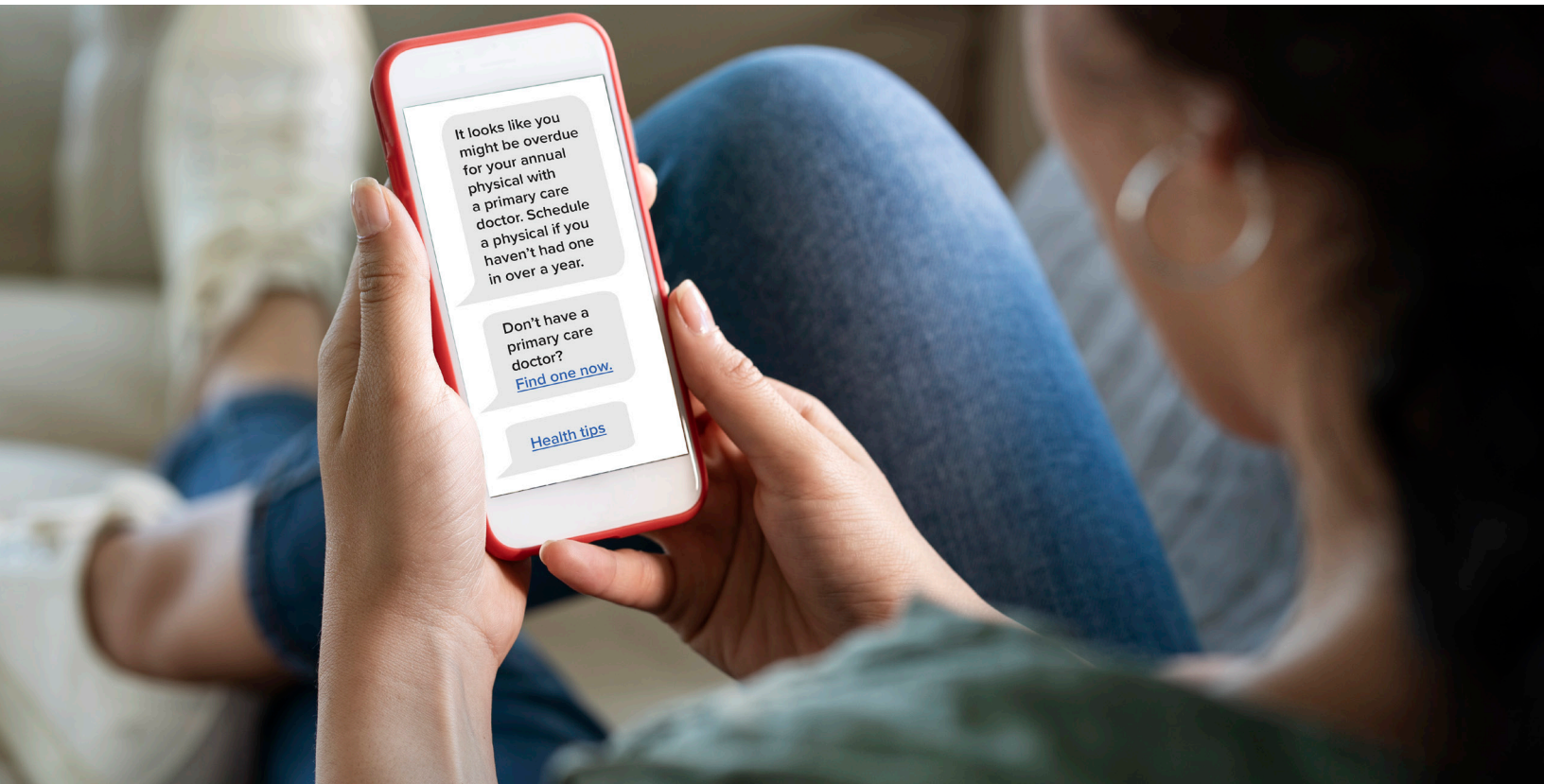
Rather get My Health Toolkit from a desktop or laptop computer?

Go to www.MyHealthToolkitFL.com and then:

- ◆ Select **Create An Account** within the **Member Login** section.
- ◆ Enter your **member ID** (from your ID card).
- ◆ Follow the instructions to create your profile, or use the subscriber's Social Security number and your birthdate.

TELL US THE BEST WAY TO REACH YOU

Occasional communications from your health plan help you stay on top of your health, save money and make the most of your benefits. Just let us know which contact channel is most convenient. We'll notify you when it's time for your annual checkup, for example, or if there's an update on a prior authorization request.



Personalized member messages — by text, mail, app notification or email — help us keep in touch by providing useful information and tips.

These could include wellness reminders or news on benefit changes. Please take a minute to update your contact preferences in My Health ToolkitSM using the tips below.

Log in to My Health Toolkit, and under My Profile, select My Account, then Contact Preferences. You can set your preferred contact for each category — for instance, to get texts from your care manager and emails about your claims.

Keeping your contact information current is the best way to make sure you don't miss any important messages!

SHOPPING FOR CARE

Find the best health care options just like you check out your choices in cars, hotels or restaurants.



“Know before you go.” It’s a smart idea before you make any important decision, including finding a new doctor or choosing a location for surgery.

Your health plan makes these decisions easier with Shopping for Care. Find it at your health plan’s **My Health Toolkit®** website.

- ◆ Find health care providers and services within our vast provider network.
- ◆ Check out cost information to make sure you’re getting the care you need at the best possible price.*
- ◆ See reviews from other patients who have rated a provider you’re considering.
- ◆ Identify the highest-quality providers in your area, with Total Care and Blue Distinction® Specialty Care designations.
- ◆ View a detailed map to help you get where you need to go.

After you’ve registered with My Health Toolkit®:

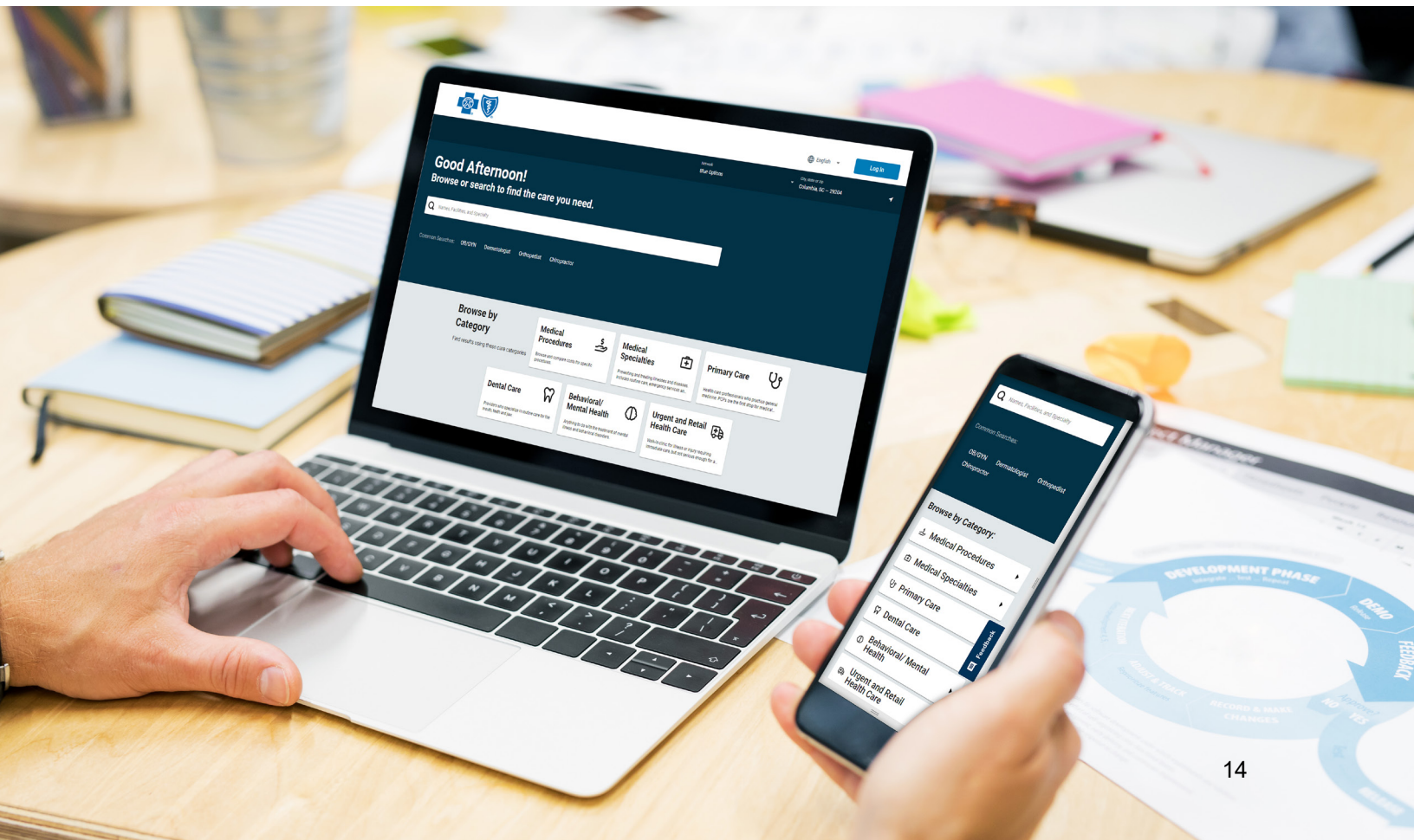
Access Shopping for Care from your computer:

- ◆ Visit your health plan’s **My Health Toolkit** site.
- ◆ Log in to your account, select **Providers and Services**, then **Find Care**.
- ◆ We’ll walk you through each step!

Or take it with you:

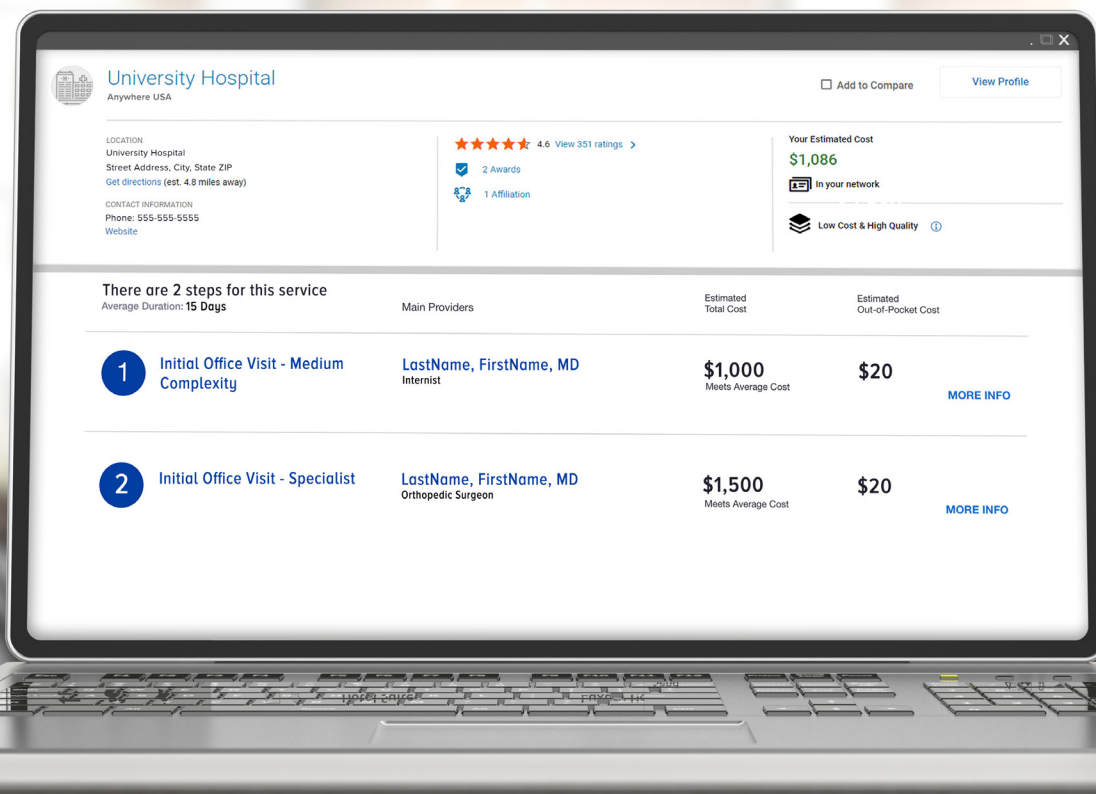
- ◆ Log in to the **My Health Toolkit** app from your mobile device.
- ◆ Select **Find Care**.

*Cost details might not be included with all plans.



“How much will it cost?”

 Estimates help you avoid surprises when the bills come.



Costs for a medical procedure — like an ultrasound, a checkup, X-rays or joint replacement — can vary by hundreds of dollars. Our Shopping for Care feature includes cost estimates to help you find the right care at the right price. (Cost information might not be included for all plans.)

Estimate your out-of-pocket expenses for medical procedures — and compare pricing details that show you the most cost-efficient providers.

- ◆ At your health plan’s **My Health Toolkit** website, log in to your **My Health Toolkit** member account.
- ◆ Select **Providers and Services**, then **Find Care**.



As you explore the **Find Care** categories further, you’ll see a **Cost Estimates** tab that’s loaded with price information about hundreds of procedures, from mammograms and MRIs to allergy testing, sleep studies, physical therapy and various types of surgery.

TIP: When you get your member ID card, use your ID number to create your **My Health Toolkit** account. Then you’ll see cost information about copays and other details specific to your health plan.

WHERE SHOULD YOU GO WHEN YOU NEED CARE?

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? Or it may be an emergency? Or you've been advised to stay home as much as possible?

Here are tips to help you choose the right type of care for various situations.

Teladoc™	Doctor's Office	Emergency Room
<p>A Teladoc virtual visit* is a great option if your doctor's office or urgent care center is closed, you're traveling, or you're not up to driving.</p> <p>With a virtual visit, you can:</p> <ul style="list-style-type: none"> ◆ Use your computer or mobile device. ◆ See a doctor who can diagnose your symptoms. ◆ Get a prescription if needed. <p>Use Teladoc for nonemergency health issues, such as:</p> <ul style="list-style-type: none"> ◆ Cold and flu symptoms, including fever, coughing and sore throat. ◆ Sinus or respiratory infections. ◆ Urinary tract infections. ◆ Seasonal allergies. ◆ Pinkeye. ◆ Migraine. ◆ Rashes, insect bites, sunburn or other skin irritations. 	 <p>Your primary care physician, or regular doctor, is the best option for routine medical care. Routine care includes:</p> <ul style="list-style-type: none"> ◆ Annual checkups and physicals. ◆ Health screenings and immunizations. ◆ Prescription refills. <p>Your regular doctor can also help with unexpected health issues that can wait a day or so. These might include:</p> <ul style="list-style-type: none"> ◆ Sprained muscles. ◆ Minor cuts and bruises. ◆ Cold and flu symptoms, including fever, coughing, sore throat and mild nausea. ◆ Sinus or respiratory infections. ◆ Urinary tract infections. ◆ Seasonal allergies. ◆ Pinkeye. ◆ Migraine. ◆ Rashes, insect bites, sunburn or other skin irritations. 	 <p>Go to the emergency room or call 911 for potentially life-threatening conditions, such as:</p> <ul style="list-style-type: none"> ◆ Heavy, uncontrolled bleeding. ◆ Signs of a heart attack, like chest pain that lasts more than two minutes. ◆ Signs of a stroke, such as numbness or sudden loss of speech or vision. ◆ Loss of consciousness or sudden dizziness. ◆ Major injuries, such as broken bones or head trauma. ◆ Coughing up or vomiting blood. ◆ Severe allergic reactions.

*Some services may have age restrictions. Teladoc doesn't guarantee prescriptions, but based on your doctor, dermatologist or psychiatrist's best judgment, they can prescribe medicine or refill prescriptions if medically necessary.

QUALITY CARE ... ANYTIME AND ANYWHERE WITH TELADOC HEALTH®

Why wait for the care you need now? Teladoc Health gives you 24/7/365 access to a board-certified physician through the convenience of phone or video consults. Teladoc Health is an independent company that provides telehealth consultation services on behalf of your health plan.



The care you need

Teladoc Health doctors can treat many of the most common medical conditions, including:

- ◆ Cold and flu symptoms
- ◆ Allergies
- ◆ Bronchitis
- ◆ Urinary tract infections
- ◆ Respiratory infections
- ◆ Sinus problems
- ◆ Behavioral health and dermatology services may also be covered.

They can also write prescriptions, according to the regulatory guidelines of your state.

When you need it

Teladoc Health has a national network of doctors ready to answer your call. With an average call-back time of only eight minutes, you can forget about spending hours in the waiting room. Now, you can quickly and easily consult an experienced doctor from the comfort of your home.

It's easy to get started

Register for Teladoc Health now — don't wait till you are sick! Call **866-789-8155**, or start by logging in to **My Health Toolkit**.

1. Select **Providers & Services, Telehealth**, then **Teladoc**. This will take you to the Teladoc site.
2. Your insurance information will appear so you can easily complete your registration.
3. From the My Health Toolkit app, select **Find Care**, then **Teladoc Health**.

Want to know more? Please visit your health plan's My Health Toolkit website to learn more about using Teladoc Health.

PRIOR AUTHORIZATION: WHAT YOU NEED TO KNOW

Your health plan requires prior authorization for certain medical tests and treatments. This is an extra step to ensure you receive the appropriate type of care for your condition. If your doctor does not receive authorization before he or she performs the service, it may not be covered by your health insurance.

What types of services require prior authorization?

Generally, prior authorization will be required for these types of services:

- ◆ Standard radiology and imaging services, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans
- ◆ Radiation therapy for cancer treatment, such as brachytherapy, image-guided radiation and stereotactic therapy
- ◆ Spine treatments, such as lumbar decompression or fusion, cervical spine procedures, and spinal epidural injections
- ◆ Hips, knees and shoulders treatments, such as arthroplasty and arthroscopy

What should you do?

Most providers will be knowledgeable about services that require prior authorization. You can ask your doctor to visit www.RadMD.com to request authorization for treatment.

What's the status of your prior authorization?

To check the status of your request:



Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.



Or call the number on the back of your membership card to speak to a customer service advocate.



PRIOR AUTHORIZATION: STANDARD RADIOLOGY SERVICES

Your health plan requires prior authorization for certain radiology and imaging services in an outpatient setting. If you are in the emergency room or an inpatient setting, you don't have to get prior authorization.

What services require prior authorization?

- ◆ Magnetic resonance imaging (MRI)
- ◆ Magnetic resonance angiogram (MRA)
- ◆ Computed tomography (CT) scans
- ◆ Positron emission tomography (PET) scans
- ◆ Myocardial perfusion imaging — nuclear cardiology study
- ◆ Multigated acquisition scan (MUGA)

What should you do?

Ask your doctor to visit www.RadMD.com to request authorization for treatment. If your provider does not receive a prior authorization before you receive services, your health plan might not cover the treatment and you could be held liable for the payment.

What's the status of your prior authorization?

To check the status of your request:



Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.



Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:

- ◆ Promote patient safety by preventing unnecessary radiation exposure.
- ◆ Help you avoid paying unnecessary out-of-pocket expenses.



PRIOR AUTHORIZATION: MUSCULOSKELETAL CARE

Your health plan requires prior authorization for certain spine treatments, including surgeries and pain management services. If you are in an emergency room, prior authorization is not required.

What treatments require prior authorization?

Inpatient and outpatient surgeries:

- ◆ Lumbar microdiscectomy
- ◆ Lumbar decompression (laminotomy, laminectomy, facetectomy and foraminotomy)
- ◆ Lumbar spine fusion (arthrodesis)
- ◆ Cervical anterior decompression with fusion: single and multiple levels
- ◆ Cervical posterior decompression with fusion: single and multiple levels
- ◆ Cervical posterior decompression (without fusion)
- ◆ Cervical artificial disc replacement
- ◆ Cervical anterior decompression (without fusion)

Outpatient pain management services:

- ◆ Spinal epidural injections
- ◆ Paravertebral facet joint injections or blocks
- ◆ Paravertebral facet joint denervation (radiofrequency [RF] neurolysis)



What should you do?

Ask your doctor to visit www.RadMD.com to request authorization for treatment. If your provider does not receive a prior authorization before you receive services, your health plan might not cover the treatment and you might have to pay.

What's the status of your prior authorization?

To check the status of your request:



Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.



Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:

- ◆ Promote patient safety by preventing unnecessary surgical procedures.
- ◆ Help you avoid paying unnecessary out-of-pocket expenses.

PRIOR AUTHORIZATION: RADIATION ONCOLOGY SERVICES

Your health plan requires prior authorization for certain radiation therapies used during cancer treatment. This is an extra step to make sure you receive the most appropriate treatment for your condition based on current medical guidelines.

Treatments that require prior authorization

These are the types of radiation treatments that require prior authorization if performed in an outpatient setting. If you don't get prior authorization before treatment, we may not cover it and the provider may bill you:

- ◆ Low-dose-rate (LDR) brachytherapy
- ◆ High-dose-rate (HDR) brachytherapy
- ◆ Two-dimensional conventional radiation therapy (2D)
- ◆ Three-dimensional conformal radiation therapy (3D-CRT)
- ◆ Intensity modulated radiation therapy (IMRT)
- ◆ Image-guided radiation therapy (IGRT)
- ◆ Stereotactic radiosurgery (SRS)
- ◆ Stereotactic body radiation therapy (SBRT)
- ◆ Proton beam radiation therapy (PBT)
- ◆ Intra-operative radiation therapy (IORT)
- ◆ Neutron beam therapy
- ◆ Hyperthermia



How to submit the request

Your doctor can visit www.RadMD.com to complete the Radiation Therapy Treatment Form. This form can be used to request prior authorization for your entire treatment plan — it will not be required for each individual procedure.

What's the status of your prior authorization?

To check the status of your request:



Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.



Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:

- ◆ Promote patient safety by preventing unnecessary radiation exposure.
- ◆ Help you avoid paying unnecessary out-of-pocket expenses.

WHEN AN EXPLANATION OF BENEFITS COMES, HERE'S WHAT TO DO WITH IT

Whenever you use your health insurance, we send you an Explanation of Benefits (EOB). It shows you a breakdown of the services you received, the cost of those services and what you might have to pay your provider. **An EOB is not a bill.**

Your EOB shows you:

- 1 How much the doctor charged.
- 2 How much you saved through your health plan.
- 3 How much your health plan paid.
- 4 How much you may still owe.
- 5 How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your in-network benefits.

On page 1, you'll find:

- A Helpful definitions.
- B How to reach us if you have questions.
- C Your member ID number.

THIS IS NOT A BILL

PAYMENTS SUMMARY for PAUL MEMBER

Your health care providers' charges	\$262.00
Amount you saved	\$26.96
Total amount your plan paid	\$55.91
AMOUNT YOU MAY OWE OR HAVE PAID PROVIDER(S)	\$179.13

Claim
07/31/2023

IN-NETWORK BENEFITS AT-A-GLANCE

Family		Member(s)	
Deductible	Out-of-Pocket	Deductible	Out-of-Pocket
\$4,200.00 Maximum	\$9,500.00 Maximum	\$3,000.00 Maximum	\$4,750.00 Maximum

A

Deductible	Out-of-Pocket
Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.	The most you could pay during a benefit plan year for your share of the cost of covered services.

B **WE'RE HERE!**

Write: Your Health Plan
P.O. Box 123456
Anytown, USA 12345

Web: Log on to www.MyHealthToolkit.com
Toll-free: 000-000-000 (Monday - Friday, 8:30 a.m. - 4:30 p.m.)
Local: 000-000-0000

Individual Claim Report
EXPLANATION OF BENEFITS

C **Plan Holder: PAUL MEMBER**
(ID # XYZ99999999999)
Benefit Plan Year: 01/01/2023 - 01/01/2024
Notice Date: 08/07/2023

On page 2, you'll find:

- A** How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your out-of-network benefits.
- B** Tips on using and making the most of your benefits.

On page 3, you'll find:

- A** Details about your claim, including the claim number and provider.
- B** When the visit took place and if the provider is in or out of network.
- C** A breakdown of what your health plan paid and how much you might owe your provider. The amount you might owe does not reflect any amount you may have already paid the provider.
- D** Additional details about your claim, including why a claim may have been denied.

Individual Claim Report: **EXPLANATION OF BENEFITS** Plan
Holder: **PAUL MEMBER** (ID # XY29999999)

OUT-OF-NETWORK BENEFITS AT-A-GLANCE

	Deductible			Out-of-Pocket		
	Maximum	Applied	Remaining	Maximum	Applied	Remaining
FAMILY	\$8,000.00	\$4,200.00	\$3,800.00	\$19,000.00	\$4,336.69	\$14,663.31
PAUL MEMBER	\$4,000.00	\$1,697.73	\$2,302.27	\$9,500.00	\$1,792.15	\$7,707.85

Deductible Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.
Out-of-Pocket The most you could pay during a benefit plan year for your share of the cost of covered services.

GETTING THE MOST FROM YOUR PLAN

Order an ID Card Online
Getting a replacement ID card is easy. Simply log in to My Health Toolkit(R) and select the Benefits tab. Click on "ID Card Request," then select "Request ID Card." Your request will be processed and your ID card will be sent to your address on file within a few days.

Network Providers Save You Money
Seeing a physician who is part of your health plan's network can help lower your health care costs. You can easily locate in-network providers by using the Doctor and Hospital Finder on our website.

Rate Your Doctor
The "Rate Your Visit" tool allows you to help other members find the right providers by writing reviews for your doctor and hospital visits. You will soon be able to read reviews provided by other members. To access the tool, log in to My Health Toolkit(R) and click on the Resources tab at the top of the page or under the Quick Links section. Review the information and provide your rating for eligible claims.

Go Green. Go Paperless
Less paper and more convenience. Sign up today to receive online Explanations of Benefits (EOBs). Visit our website and log in to My Health Toolkit(R).

Information When You Need It
Our website offers tools and information any time you need it. You can find a provider for health care services, access information regarding your benefits and find resources for a healthier lifestyle.

Individual Claim Report: **EXPLANATION OF BENEFITS** Plan
Holder: **PAUL MEMBER** (ID # XY29999999)

MEDICAL CLAIMS for patient: **PAUL MEMBER** THIS IS NOT A BILL

Provider and Service Information		Charges and Insurance Payments			Breakdown of Member Responsibility				
Claim Number	Service Type	Provider Charges	Covered Expense	Your Plan Paid	Copay	Deductible	Coinsurance	Not Covered	Amount You May Owe or Have Paid
Provider Group	Date of Service(s) Network							see Comments below table	
00000000000000000000	OFFICE VISIT(S) 07/31/2023 In-Network	240.00	217.91	42.20	0.00	165.17	10.54	0.00	175.71
DERMATOLOGY AND S	OFFICE LAB/PATH 07/31/2023 In-Network	22.00	17.13	13.71	0.00	0.00	3.42	0.00	3.42
Statement Period Total		262.00	235.04	55.91	0.00	165.17	13.96	0.00	179.13

Comments
1 HERE'S WHERE YOU'LL FIND COMMENTS ABOUT YOUR CLAIM, IF APPLICABLE.

Every EOB includes important information about how to appeal a denial of your claim. This will help you figure out what to do if you disagree with any of the benefits decisions made on this claim.

Check your EOBs through the **My Health Toolkit®** app or by logging in online. Select **Claims & Authorizations**, **Claims**, and then **Health Claims**.

Choose how you want to receive your EOBs — text, email or mail

You can set your contact preferences when you register for **My Health Toolkit**. Log in and select **Profile, My Account** and then **Contact Preferences**.

If you get paper EOBs, an EOB will be mailed to you after a claim has been finalized. If you've opted for online delivery, you'll get an email or text when your EOB is ready to view in **My Health Toolkit**.

MAKE SURE YOU'RE COVERED

Why coordination of benefits is important


Do you have other health insurance?


Coordination of benefits — COB, for short — affects your benefits when you or a family member also is covered under another health insurance plan. COB makes sure the right plan processes your claims first. It prevents overpayments and duplication of services. And that helps keep costs down for everyone.

Examples of other insurance: These may include coverage under a spouse's insurance plan, Medicaid or Medicare.

What you need to do: Be sure we have up-to-date information about your other insurance. That way, we can process your claims correctly and promptly.

- ◆ If you receive an Other Health Insurance Questionnaire in the mail, fill it out and return it right away. Even if you do not have coverage with another health plan, we need to know that, too.

◆  You also can give us this information by logging in to **My Health Toolkit®**. Select **My Plan Benefits, Health,** then **Other Health Insurance**.

◆  Or call the number on the back of your membership card and provide the information to a customer service advocate.

We appreciate your help with this.



Getting benefits after you have declined coverage

Special enrollment rights may apply to you, your spouse or other dependents even after you have declined coverage.

- ◆ For example, you might have declined coverage because other health insurance or another group health plan was in effect. Later, you may want to seek coverage with this plan if you or your dependents became ineligible for the other coverage or the employer stopped contributing to the other coverage. You must request our coverage within 30 days after this other coverage ends OR after the employer contribution stops.

- ◆ You also may be able to get coverage if you have a new dependent because of marriage, birth, adoption or placement for adoption. Again, you must request enrollment within 30 days of the event.

Please note that you may have been required to provide a written statement when you declined enrollment with us. If you did not provide this written statement, this health plan is not required to grant special enrollment rights to you or your dependents.


For more information, contact your employer's benefit department.

MEMBER PERKS

Discounts for you – just for being Blue!

In addition to superior health coverage, your membership provides access to exclusive discounts on a variety of products and services. The member discounts program includes items that generally are not covered by health insurance.



 Log in to My Health Toolkit, select the **Resources** tab, then **Blue365® Discounts**. On a mobile device, select **Menu**, then **Blue365® Discounts**. You'll find details on discounts for:



Fitness

- ◆ Gym memberships
- ◆ Wearable fitness devices
- ◆ Activewear
- ◆ Home fitness equipment
- ◆ Vitamins and nutritional supplements



Personal care

(please note that some restrictions may apply for these services.)

- ◆ Allergy relief
- ◆ Acupuncture
- ◆ Chiropractic services
- ◆ Massage therapy
- ◆ Hair restoration
- ◆ Teeth whitening



Healthy eating

- ◆ Weight loss programs
- ◆ Cookbooks and recipes
- ◆ Online cooking classes



Hearing and vision

- ◆ Hearing aids
- ◆ Eyewear



Lifestyle

- ◆ Travel clubs
- ◆ Vacation packages
- ◆ Pet care

HEALTHY LIVING IS JUST A DEAL AWAY

Join Blue365 and start saving today!

Blue365[®]



Blue365 gives you access to savings across all aspects of your life — including savings on Fitbit devices, low monthly cost gym membership access at over 10K locations, discounts on healthy, organic meal delivery services from Sun Basket and much more!

Register now for free to take advantage of Blue365.

It's an online destination where participating members can find healthy deals and exclusive discounts, all you need is your BlueCross BlueShield of South Carolina member ID card to get started.

Exclusive savings from:



Get started today at www.Blue365Deals.com/register.



Blue Cross and Blue Shield of Florida, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association.

The Blue365 program is brought to you by the Blue Cross Blue Shield Association. The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and/or Blue Shield Companies. Blue365 offers access to savings on health and wellness products and services and other interesting items that Members may purchase from independent vendors, which are not covered benefits under your policies with your local Blue Company, its contracts with Medicare, or any other applicable federal healthcare program. These products and services will be offered to you through the entire benefit year. During the year, the independent vendors may offer additional discounts on these products and services. To find out what is covered under your policies, contact your local Blue Company. The products and services described on the Site are neither offered nor guaranteed under your Blue Company's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding your health insurance products and services may be subject to your Blue Company's grievance process. BCBSA may receive payments from vendors providing products and services on or accessible through the Site. Neither BCBSA nor any Blue Company recommends, endorses, warrants, or guarantees any specific vendor, product or service available under or through the Blue365 Program or Site.

CARE COORDINATOR

Call one number to connect with the solutions you need



Navigating your health care can be confusing. How can you find a new doctor? What services are covered under your benefits? Did the hospital bill you correctly? How can you cope with a medical problem?

We can help, by linking you with someone who knows all about your health plan. You'll talk to a customer service advocate or to a Care Coordinator who can guide and support you with solutions for your health care needs

Your Care Team can help you:

Understand your insurance plan

Stay informed about your benefits, make sure you are using them effectively and learn about online tools.

Choose the right care

Get help finding a doctor, choosing a hospital, and comparing costs for treatments or medications.

Navigate the system

Get help communicating with providers, finding care for a particular condition and even scheduling appointments.

Review your bills

Have questions about a bill? Get answers about costs as well as help reconciling any billing errors.

Call 833-644-1299 to speak to a Care Coordinator representative (Mon-Fri. 8am-8pm).

HELP ALONG THE WAY TO BETTER HEALTH

Ready to get on track with your health but not sure where to start? You don't have to figure it out on your own. Your health plan includes free care management programs and resources to help you make positive, meaningful changes at your own pace.

What is care management?

It's a personalized approach that gives you support and lots of options. A care manager can help you reach your health goals, make the most of your benefits and serve as your advocate if you run into obstacles receiving care.

This program is included in your benefits for no additional cost. In some cases, your care manager may help you find ways to lower your medical or pharmacy costs. Connect digitally or by phone!

We offer care management for these conditions:

- ◆ Attention-deficit hyperactivity disorder (adults)
- ◆ Asthma (adults and children)
- ◆ Bipolar disorder
- ◆ Heart disease and heart failure
- ◆ Chronic obstructive pulmonary disease
- ◆ Depression
- ◆ Diabetes (adults and children)
- ◆ High blood pressure and high cholesterol
- ◆ Metabolic health (metabolic syndrome and prediabetes)
- ◆ Migraine
- ◆ Recovery support for substance use disorder

Case management

If you experience complex or difficult health issues, your nurse care manager will reach out to you to provide support. Things he or she can help with include cancer, transplants, end-stage renal disease, trauma and neonatal intensive care.

Maternity Care

- ◆ Personalized digital support during and after your pregnancy
- ◆ On-demand access to a maternity nurse



Ready to become a healthier you?



If you qualify for one of our care management programs, we will reach out to you with a phone call, email, text or letter to help you get started. If you have questions, connect with us by phone at **855-838-5897** or through our app, My Health Planner. Just search for **My Health Planner** in the Apple App Store or Google Play and enter access code **ACTNOW** to get started.

When Weight Management Is Part of Your Story



The weight management chapter of My Health Novel is designed to match you with helpful resources and tools based on your specific health needs.

It lets you access health management mobile apps at no cost to you.

When you qualify and sign up, you'll get access to health coaching, nutrition guidance, digital tools, group support and more to keep you on track.

How it works:

1. Log in to [My Health Toolkit](#)®.
2. Select [Wellness & Care Management](#), [Wellness Programs](#), then [My Health Novel](#).
3. Take a quick, one-minute assessment.
4. You'll receive your recommended programs and resources available to you.

Find support to help you reach and stay at a healthy weight!



YOUR HRA

A health reimbursement arrangement helps you stretch your health care dollars

Your health insurance plan is a great advantage as you try to stay healthy. But as you've probably noticed, it doesn't cover everything. A health reimbursement arrangement (HRA) can help with out-of-pocket expenses. AccrueHealth administers HRAs on behalf of your health plan.



Your employer deposits funds in your HRA. You can use this money to cover medical expenses for yourself and your family.

Other HRA features:

- ◆ It reimburses qualified medical expenses that are not covered by your health plan, such as copays and deductibles.
- ◆ Depending on your plan, you can either pay for qualified medical expenses with an AccrueHealth debit card or pay out of pocket and then file a claim for reimbursement from your HRA.
- ◆ An HRA can be a stand-alone fund, or it can be integrated with a consumer-driven health plan.

- ◆ HRA plan designs vary. Unused funds may or may not roll over from year to year. Also, you might or might not retain access to the HRA if you leave the company. Your human resources department has details on your plan.

How an HRA saves you money:

- ◆ It provides funds for a wide range of health services for which you would otherwise pay out of pocket.
- ◆ The funds you receive do not count toward your gross income for tax purposes.



Helpful details:

- ◆ Your employer puts money into your HRA and defines which medical expenses are eligible.
- ◆ Contributions your employer makes are excluded from your gross income, so they are not taxable.
- ◆ Save your receipts when you spend HRA dollars. You might need itemized invoices to verify expenses or for reimbursement requests.

Your human resources department can provide a more comprehensive list of eligible and ineligible expenses. For more about federal requirements and what HRAs can cover, see Publication 502 at www.IRS.gov.

HEALTH SAVINGS ACCOUNTS: HOW DO THEY WORK?

It's not always easy to predict your medical expenses for the year. But setting aside some of your pretax earnings in a health savings account (HSA) can be a good strategy to plan for these expenses. Our administrator for HSAs, AccrueHealth, lets you handle this task in a way that's easier on your budget.



You can set up an HSA if you are opting for a consumer-driven health plan.

Here's how it works:

- ◆ Through payments or automatic deposits, you place a certain amount of money in your HSA before taxes are taken out.
- ◆ Your employer can help by also making deposits into your account, which earns interest over time.
- ◆ Under your consumer-driven health plan, you can use the funds in your HSA for qualified medical expenses — for example, seeing the doctor when you have a sinus infection, or filling prescriptions at the pharmacy.
- ◆ There's no “use it or lose it” requirement. Money left in your HSA can roll over to next year — or even come with you if you change jobs. And payments for medical services are tax-free.

Not everyone is eligible for an HSA.

You cannot be:

- ◆ Covered by a health plan that is not compatible with HSAs.
- ◆ Claimed as another person's income tax dependent.
- ◆ Enrolled in Medicare Part A or B, or the Department of Veterans Affairs (VA) health care benefits.
- ◆ Eligible for an HSA if your spouse has a health care flexible spending account (unless his or her account has dental and vision reimbursements only).

Qualifying expenses

HSA funds can cover costs for all this and more:

- ◆ Copays, deductibles, coinsurance
- ◆ Doctor's office visits, exams, lab work, X-rays
- ◆ Hospital charges
- ◆ Prescription drugs
- ◆ Dental exams, X-rays, fillings, crowns, orthodontia
- ◆ Vision exams, frames, contact lenses and solution, laser vision correction
- ◆ Physical therapy
- ◆ Chiropractic care
- ◆ Medical supplies
- ◆ Over-the-counter medications
- ◆ COBRA premiums
- ◆ Personal hygiene products

Expenses that are not eligible include these:

- ◆ Expenses incurred before opening your HSA
- ◆ Cosmetic procedures or surgery
- ◆ Dental products for general health

For specific guidance on eligible expenses, please see IRS Publication 502.



Online & mobile access

Link up with AccrueHealth through My Health Toolkit (web or mobile) or through the AccrueHealth mobile app.

Using your HSA



You can use your AccrueHealth debit card to pay a provider for eligible HSA expenses.

If the debit card is not an option, pay out of pocket and request reimbursement online, through the member portal or app, or by mail or fax.

PERSONAL SPENDING ACCOUNTS



Link up with AccrueHealth through your My Health Toolkit® account at www.MyHealthToolkitFL.com. You can view your account balance, submit claims, store receipts and much more.

Health Reimbursement Account (Plan 1 – HRA only)

An HRA allows you and your dependents to receive reimbursements for qualified out-of-pocket health expenses. Your employer deposits a set amount of money into a tax-free account, which you can use to pay for medical expenses. In addition to the HRA, your employer offers a traditional health plan to cover other medical bills. For a complete list of eligible and ineligible HRA expenses, consult your Human Resources department. Or visit the Internal Revenue Service website at www.irs.gov* and view Publication 502.

Health Savings Account (Plan 2 – HSA only)

An HSA is a special savings account that allows you to set aside pretax or after-tax funds for future medical and retirement expenses. You can invest these funds in your choice of stocks or mutual funds or manage the HSA like a traditional savings account. A qualified bank, financial institution or trustee can administer your HSA. You can use your HSA funds to pay your first medical expenses, including office visits, prescriptions and other health care costs. The amount you spend from the HSA for covered medical expenses counts toward your health plan deductible. Once you meet the deductible, the health plan coverage kicks in, and you are only responsible for coinsurance payments.

The 2026 HSA contribution limit is \$4,400. Family max \$8,750. Catch-up contribution for those age 55 and over is \$1,000.

*These links lead to a third-party website. The Internal Revenue Service is solely responsible for the contents and privacy policy on its site.

ADULT WELLNESS GUIDELINES

Adult health — for ages 18 and over

Preventive care is very important for adults. By making healthier choices, you can improve your overall health and well-being. These healthy choices are a good start:

- ◆ Eat a healthy diet.
- ◆ Get regular exercise.
- ◆ Don't use tobacco products.
- ◆ Limit alcohol use.
- ◆ Strive for a healthy weight.
- ◆ Take medications as prescribed by your doctor.

Adult Recommendations

Screenings	
Physical Exam	Every year or as directed by your doctor
Body Mass Index (BMI)	Every year
Blood Pressure (BP)	At least every two years
Colon Cancer Screening	Beginning at age 45 in consultation with your doctor — You have three options: a colonoscopy every 10 years, a flexible sigmoidoscopy every five years or a blood test annually.
Diabetes Screening	Screening beginning at age 45 — If you have high blood pressure or high cholesterol, are overweight, or have a close family history of diabetes, you should consider being screened earlier.
Lung Cancer Screening	If at high risk, talk with your doctor.

Immunizations					
	19 – 21 years	22 – 26 years	27 – 49 years	50 – 64 years	65 and older
Influenza (Flu)*	Once each year				
Tetanus, Diphtheria and Pertussis (Tdap)*	One dose with a booster every 10 years				
Herpes Zoster (Shingles) — RZV*					Two doses for those 50 and older
Varicella (Chickenpox)*	Two doses				
Pneumococcal (Pneumonia)*					Two doses
Measles, Mumps and Rubella (MMR)*	One or two doses if no evidence of immunity				
Human Papillomavirus (HPV) — Female*	One or two doses if no evidence of immunity				
Human Papillomavirus (HPV) — Male*	Two or three doses depending on age at series initiation				
Hepatitis A**	Two or three doses for at-risk adults — Discuss with your doctor if this vaccine is right for you.				
Hepatitis B**	Three doses for at-risk adults — Discuss with your doctor if this vaccine is right for you.				
Meningitis**	One to three doses depending on indication — This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				
Haemophilus Influenzae Type B (Hib)*	One to three doses depending on health risks — This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				

*Recommended for most adults.

**Recommended for adults with certain health risks.

WOMEN'S HEALTH

**Sure, multitasking is your superpower.
But pay attention to your own health, too.**



Your ability to keep everything and everyone in order is truly impressive. But remember that your powers have a limit. Before you can save the world, you must first take care of yourself.

Make sure everything is healthy underneath that cape by scheduling regular health screenings. These recommendations are in addition to the standard wellness guidelines for adults.

Women's Recommendations

Mammogram	Women 40 and up should get checked yearly.
Cholesterol	Ages 30 – 35 should be tested if at high risk. Women 45 and older should be tested.
Pap Test	Every three years for ages 21 – 65. Or, Pap test and HPV test every five years for ages 30-60. Those who've had a hysterectomy or are over age 65 might not need a Pap test.*
Osteoporosis Screening	Screenings should begin at age 65 or at age 60 if risk factors are present.*
Aspirin Use	At ages 50 – 79, talk with your doctor about the benefits and risks of aspirin use.
Pelvic Exam	Ages 21 and over should have an exam every year.*

*Recommendations may vary. Discuss screening options with your doctor, especially if you are at increased risk.

Sources: American Cancer Society, U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

MEN'S HEALTH

Even the toughest machines depend on regular maintenance



Preventive care is important to men's health. If you're going to keep firing on all cylinders, you need to make time for tuneups. So, let's man up and schedule that appointment!

In addition to the standard wellness guidelines for adults, men should discuss these recommendations with their doctors.

Men's Recommendations

Cholesterol	Ages 20 – 35 should be tested if at high risk. Men ages 35 and over should be tested.
Abdominal Aortic Aneurysm	Get checked once between ages 65 and 75 if you have ever smoked.
Aspirin Use	At ages 50 – 79, talk with your doctor about the benefits and risks of aspirin use.
Prostate Cancer Screening	Ages 55 and older, discuss benefits and risks with your doctor.*

Sources: American Cancer Society, U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

*Recommendations may vary. Discuss options with doctor, especially if you are at increased risk.

RXBENEFITS PRESCRIPTION PROGRAM

The City's prescription drug program is administered by RxBenefits. RxBenefits is available for eligible employees and their dependents enrolled in the Blue Cross Blue Shield medical program. The costs per pay period are included with the medical rates. For information about your prescription drug program, please call **(800) 334-8134** or visit their website at optimize.rxbenefits.com/ refer to the Benefit Summary on our website at sarasotafl.gov/Department-Pages/Human-Resources/Benefits-and-Compensation

Member Services for Member Support

RxBenefits' experienced, high-performing call center team delivers a superior level of service

Availability

Member Services is available from 8:00 AM to 9:00 PM ET on Monday – Friday. Member Services can assist you with questions or concerns regarding your pharmacy benefits such as:

- Benefit Details
- Claims Status
- Pharmacy Network
- Coverage Determination/Inquiries
- Mail and Specialty Scripts
- Pharmacy Information
- Clinical Programs

Member Services can be reach at by calling (800) 334-8134 or emailing

CustomerCare@rxbenefits.com.

Call center hours 8AM-9 PM Monday-Friday

Paper Claims

Submit prescription receipts along with your specific PBM's claim form to be processed for direct reimbursement. Claims should be mailed to the address listed on your ID card or fax them to RxBenefits at **(205) 449-5225**.



RXBENEFITS PRESCRIPTION PROGRAM

Access at your fingertips!

My RxBenefits

By registering for My RxBenefits you'll gain robust information related to your pharmacy benefits whenever is convenient for you, 24 hours a day, 7 days a week. Registering for My RxBenefits will allow you to:

- Chat with a live agent Monday-Friday 10AM-7PM
- Access real time prior authorization status, including explanations of determinations.
- View, download, and email copies of ID cards
- View 18 months of pharmacy claims (including claims for eligible dependents)
- Access your account across multiple devices
- Manage your communication preferences
- View pharmacy benefits coverage information

CVS Caremark App

Now you can manage your prescription benefits anytime, anywhere. Download the CVS Caremark app for on-the-go access with these helpful tools and resources:

- **Easy Refills**—Scan the barcode on your Rx label to refill available prescriptions.
- **View ID Card**—No need to carry your benefit ID card. With the app, you always have it on hand.
- **Fill New Prescriptions**—Take a photo of the front and back of your new paper prescription and CVS Caremark Mail Service Pharmacy will take it from there.
- **Pharmacy Locator**—Find in-network retail pharmacies near you.
- **Manage Your Profile**—Set your notifications, update shipping and billing information, and more.

WELLNESS INCENTIVE PROGRAM

The City of Sarasota is committed to wellness and health and continues to adopt plans to encourage healthy behaviors. The City's benefit program includes incentives for eligible retirees who complete the biometric screenings and are enrolled in the City of Sarasota's Blue Cross Blue Shield Medical plans.

Wellness Results: How it works

This program is completely voluntary. If you choose to participate, you will need to go to your Primary Care Physician or make an appointment at the Health Center for blood work. At the health center, you can call or go online to schedule an appointment for a fingerstick and visit with the provider to review results. You can also go to your own doctor for completion. The wellness incentive is a pass/fail based on completion of the biometric screenings.

Coverage Tier	Amount deposited into HRA or HSA
Single	\$200
Plus One	\$500
Family	\$700

It is the **participant's responsibility** to return the Wellness Incentive Form to Human Resources or upload into Workday before the deadline. Current retirees' deadline to return the form to Human Resources is October 26, 2026. You can turn in your form by:

- Fax (941) 263-6336
- Email Fitzroy.Hibbert@sarasotafl.gov
- Mail to 1565 1st Street, Annex Building 3rd Floor, Sarasota, FL 34236



UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE

The City provides coverage, administered by AARP / UnitedHealthcare, for eligible retirees and their dependents. This plan is available to retirees that are Medicare eligible. You must be enrolled in Medicare Part A & Part B as a retiree. The costs per month for coverage are listed in the premium table below. Retirees (Pre-93 Hire) can continue to use the Health Center if enrolled in the Medicare Advantage Plan. **For information about your medical plan, please refer to the benefit summary on our website at sarasotafl.gov/Department-Pages/Human-Resources/Benefits-and-Compensation or contact AARP Customer Service at (866) 658-8344.**

Retiree Medicare Advantage Plan (PPO) for 2026

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly
Retiree Only (Age 65+)	\$0.00	\$646.97
Retiree's Spouse (Age 65+)	\$646.97	\$646.97

UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE

Benefit Name	In Network	Out of Network
Annual Deductible	None	None
Annual Out of Pocket Maximum	\$0	\$0
Primary Care Physician Office Visit	\$0	\$0
Specialists Office Visit	\$0	\$0
Virtual Office Visit	\$0	\$0
Telemedicine	\$0	\$0
Emergency Room (Includes Worldwide coverage)	\$0	\$0
Urgent Care Facility (Includes Worldwide coverage)	\$0	\$0
Clinical Laboratory Services	\$0	\$0
Outpatient X-ray Services	\$0	\$0
Diagnostic Radiology Service	\$0	\$0
Inpatient Hospital Stay	\$0 Per Admit	\$0 Per Admit
Outpatient Hospital	\$0	\$0
Durable Medical Equipment	\$0	\$0
Diabetic Shoes & Inserts	\$0	\$0
Routine Hearing Exam for Hearing Aids	\$0	\$0
Hearing Aid Allowance - includes digital hearing aids. Benefit is for ears combined.	\$500	
Ambulance Services	\$0	\$0
Routine Vision Exam (Every 12 months)	\$0	\$0
Physician Services at Outpatient Hospital or Surgical Center	\$0	\$0
Mental Health / Alcohol & Substance Abuse		
Inpatient	\$0 Per Admit	\$0 Per Admit
Outpatient Facility	\$0	\$0
Physician Office Visit	\$0	\$0
Prescription Drugs		
Tier 1– Generic	\$5	Not Covered
Tier 2 – Preferred Brand Name	\$10	
Tier 3 – Non-Preferred Brand Name	\$20	
Tier 4 – Specialty Drugs	\$20	
Mail-Order Program (90 Day Supply)	\$10 / \$20 / \$40 / \$40	

United Healthcare / AARP is an independent company that offers administrative services on behalf of your employer group health plan.

PRE-1993 RETIREE REIMBURSEMENT STIPEND

Pre-93 retirees have the option to enroll in the Stipend program. This allows the retiree to enroll in a medical plan outside of the City self-funded plan and United Healthcare Medicare Advantage option and receive funds (submit receipts for reimbursement) to pay for the medical plan premium. The amount that will be reimbursed will match the City of Sarasota's United Health Care Advantage Plan. The Stipend plan covers medical premiums, prescriptions, and dental claims (receipts must be submitted to vendor in order to receive reimbursement for each expense). This plan is only for Pre-93 retirees and does not include spousal coverage. If a Pre-93 Spouse is not yet Medicare eligible, they can remain on the City's Blue Cross medical plan as a standalone dependent until they turn 65 or reach Medicare eligible age. The cost is \$673.82 per month for Plan 1-HRA or \$590.03 per month for Plan 2-HSA.

Retiree Reimbursement Stipend for 2026

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Monthly Stipend Reimbursement Amount
Retiree Only	\$646.97

Documentation is required to be submitted to Human Resources showing the effective date of the plan.

METLIFE DENTAL INSURANCE

The City offers dental insurance administered by MetLife. The cost per month is listed in the premium table below. A brief description of the Dental PPO Plan is below and a summary of the plan's schedule of benefits is on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary, contact MetLife at (800) 942-0854 or visit MetLife's website at www.metlife.com/mybenefits and type in City of Sarasota.

Base Plan 1 Dental PPO

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly**
Retiree Only	\$5.49	\$35.00
Retiree + One	\$10.97	\$65.00
Retiree + Family	\$16.45	\$95.00

Buy Up Plan 2 Dental PPO

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly**
Retiree Only	\$11.54	\$42.14
Retiree + One	\$21.47	\$78.26
Retiree + Family	\$31.37	\$114.38

**The 2% COBRA administrator fee is charged on the above rates.

Please note the following:

- Each member may receive up to 2 cleanings per year, when utilizing an in-network provider, which must be scheduled 6 months apart.
- Teeth missing prior to coverage under the plan are not covered.
- Waiting periods and age limitations may apply to some services.
- For any dental work expected to cost \$200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of your dental provider. This will assist you with determining your approximate out-of-pocket costs should you have the dental work performed.

METLIFE DENTAL INSURANCE

Network	PDP Plus			
	Base PPO Plan 1		Buy Up PPO Plan 2	
Benefits	In Network	Out of Network	In Network	Out of Network
Calendar Year Maximum Per Member	\$1,500		\$3,000	
Calendar Year Deductible (CYD) Per Member	\$50		\$50	
Calendar Year Deductible (CYD) Per Family	\$150		\$150	
Waived for Class 1 Services?	Yes		Yes	
CLASS 1: DIAGNOSTIC & PREVENTIVE	In Network	Out of Network*	In Network	Out of Network*
Routine Oral Exam (2 Per Year)	Plan Pays: 80% Deductible Waived*		Plan Pays: 80% Deductible Waived*	
Routine Cleanings (2 Per Year)				
Bitewing X-rays (2 Per Year)				
Panoramic X-rays (1 Per 3 Years)				
Full Mouth X-Rays (1 Per 3 Years)				
Fluoride Treatments (Annually to Age 19)				
Sealants (Every 3 Years to Age 14)				
Space Maintainers (Non-Orthodontic Treatment)				
CLASS 2: BASIC RESTORATIVE				
Fillings (Amalgam & Composite)	Plan Pays: 80% After CYD*		Plan Pays: 80% After CYD*	
Routine Extractions				
Root Canal Therapy				
Periodontal Scaling (Entire Mouth)				
Oral Surgery				
General Anesthesia				
CLASS 3: MAJOR RESTORATIVE				
Bridges	Plan Pays: 50% After CYD*		Plan Pays: 50% After CYD*	
Crowns				
Dentures				
CLASS 4: ORTHODONTIA				
Lifetime Maximum	\$1,500		\$1,500	
Benefit	50% Coinsurance; No Deductible*		50% Coinsurance; No Deductible*	

*Out of Network Balance Billing

- For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Dental PPO - Participating and Non-Participating Providers section in your Summary Plan Description.
- Late entrant limitation will apply for 12 months on all services

How to Find a Provider

To search for a participating provider, contact MetLife's Customer Service or **(800) 942-0854** or visit MetLife's website www.metlife.com/mybenefits and type in **City of Sarasota** and click on Find a Dentist.

METLIFE does NOT provide ID cards.



MetLife is an independent company that offers administrative services on behalf of your employer group health plan.

METLIFE VISION INSURANCE

The City offers vision insurance through MetLife. The employee costs and benefits are provided in the below tables. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary, contact MetLife (855) 638-3931 or visit MetLife's website at www.metlife.com/mybenefits and type in City of Sarasota or scan the below QR code to download the app.



Tier of Coverage	Retiree Cost Monthly**
Retiree Only	\$5.60
Retiree + One	\$10.63
Retiree + Family	\$13.86

Network: VSP	MetLife Vision PPO Plan	
Services	In Network	Out of Network
Eye Exam	\$10 Copay	Up to \$45 Reimbursement After \$10 Copay
Materials	\$20 Copay	\$20 Copay Applies. Plan Reimbursement Based on the Type of Service
Frequency of Services	In Network	Out of Network
Examination		12 Months
Lenses		12 Months
Frames		12 Months
Contact Lenses		12 Months
Lenses	In Network	Out of Network
Single	Paid In Full After Copay	Up to \$30 Reimbursement After Copay
Bifocal		Up to \$50 Reimbursement After Copay
Trifocal		Up to \$65 Reimbursement After Copay
Frames	In Network	Out of Network
Basic, Preferred or Non-Preferred	\$150 Retail Allowance: 20% discount on balance	Up to \$70 Reimbursement After Copay
Contact Lenses*	In Network	Out of Network
Non-Elective (Medically Necessary)	Covered In full After Copay	Up to \$210 Reimbursement After Copay
Elective Lenses	\$150 Retail Allowance After Copay	Up to \$105 Reimbursement After Copay
Standard Fitting	Covered in full with a maximum copay of \$60	Applied to contact lens allowance
Specialty Fitting	Covered in full with a maximum copay of \$60	Applied to contact lens allowance

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

**The 2% COBRA administrator fee is charged on the above rates.

How to Find a Provider

To search for a participating provider, contact MetLife's Customer Service or (800) 942-0854 or visit MetLife's website www.metlife.com/mybenefits and type in City of Sarasota and click on Find a Provider.

MetLife does NOT provide ID cards.



MetLife is an independent company that offers administrative services on behalf of your employer group health plan.

CANARX PRESCRIPTION DRUG PROGRAM

The City of Sarasota offers a prescription drug benefit through CANARX. CANARX is a voluntary Name Brand (only) prescription drug program that is available to eligible retirees and their dependents on the Blue Cross Blue Shield medical plan.

All member copayments have been waived for this program only.

- \$0.00 co-pay for all prescriptions offered through the program. Check formulary for available medications.
- Prescriptions shipped directly to your home with no shipping and handling costs.
- No out-of-pocket expenses.
- Before ordering through CANARX, you or your doctor must attest that you have been taking your prescribed medication for at least 30 days – this is to ensure you have not experienced any complications with the medication.

Getting started is super easy!

1. Check to see if a medication is offered. Call **1-866-893-6337** and speak with a CANARX representative or view the complete formulary and print enrollment material at www.canarx.com (**WebID: SARASOTA**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit Your Completed and Signed Enrollment Form, Original Prescription and copy of your Legal Photo ID by one of the following methods:
 - Mail:
CANARX
PO BOX 3009
Windsor, ON CANADA
N8N 2M3
 - Secure Upload: CANARXDOCS.COM
 - Fax: 1-866-715-6337 (NOTE: Faxed prescriptions must be sent directly from the physician's office.)
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

Visit the www.canarx.com (**WebID: SARASOTA**) for more information including:

- Additional Forms
- Frequently Asked Questions (FAQs)
- Video Overview
- List of Medications



STANDARD LIFE INSURANCE *For Pre 93 Retirees*

Basic Term Life & Accidental Death & Dismemberment Insurance

Eligible retirees (hired prior to October 1, 1993) are provided \$3,000 of Basic Term Life coverage.

Voluntary Life Insurance

Voluntary Life insurance is **only available if additional voluntary term life coverage with Standard Insurance Company is in force at the time of retirement.** Retirees may not add additional insurance on themselves through Standard Life at a later date. Voluntary Life insurance offers coverage for yourself, your spouse and/or child(ren) at set benefit levels.

- Units can be purchased for the retiree in the amounts of \$7,000 or \$17,000.
- Premium are based on age and coverage level.
- Premiums are not locked in and increase when age bands are crossed.

Voluntary Spouse/Dependent Child Life Insurance

May be converted to \$1,500 for spouse and/or dependent at the time the employee retires. The policy must have been in force already. Cost is a flat monthly rate of \$1.50.

Customer Service: For more information about the benefits provided through this policy, please contact The Standard at **(800) 348-3226** or visit www.standard.com.

Always remember to keep your beneficiary forms updated. You may update your beneficiary at any time through Human Resources or Workday.

Retiree Voluntary Life		
Retiree Age	Monthly Rates per \$7,000	Monthly Rates per \$17,000
<30	0.42	1.02
30-34	0.56	1.36
35-39	0.63	1.53
40-44	0.84	2.04
45-49	1.47	3.57
50-54	2.59	6.29
55-59	4.27	10.37
60-64	5.25	12.75
65-69	9.17	22.27
70-74	14.42	35.02
75 & over	15.61	37.91

Please note If you were hired after October 1st 1993 and retired after January 1st 2025, you only have the option to port your current life coverage upon retirement. This will *not* be a city paid benefit.



KEY CONTACTS

Please refer to this list when you need to contact one of your benefits vendors. For general information, contact your Human Resources Department.

<u>Benefit</u>	<u>Carrier</u>	<u>Contact Information</u>
Human Resources	City of Sarasota	Fitzroy Hibbert Fitzroy.Hibbert@SarasotaFL.gov (941) 263-6338
Medical	BlueCross BlueShield	(833) 644-1299
Health Reimbursement Account & Health Savings Account	Accrue Health	844-643-3099
Prescription Drug & Mail Order Program	RxBenefits	(800) 334-8134
Medicare Advantage PPO Plan	UnitedHealthcare / AARP	(866) 658-8344
Telehealth– Virtual Visits	Teladoc	(866) 789-8155
Marathon Health Center	Marathon	(941) 893-2556
Dental	MetLife	(800) 942-0854
Vision	MetLife	(855) 638-3931
Life	The Standard	(800) 348-3226
Free Prescription Drug Program	CanaRx	(866) 893-6337
Escalated Medical & Dental Claims Issues	Brown & Brown	Dani Hochmuth danielle.hochmuth@bbrown.com (386) 333-6089

NON-DISCRIMINATION STATEMENT AND FOREIGN LANGUAGE ACCESS

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, religion, health status in our health plans, when we enroll members or when we provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice **(TDD 711)**.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at **800-832-9686** or the U.S. Department of Health and Human Services, Office for Civil Rights at **800-368-1019** or **800-537-7697 (TDD)**.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bík'a'aná nílwo'ígíí díí Béeso Ách'ááh naa'níłgi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíł bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'í' ha desdizih nínízingo, kojí' béesh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

We're glad to have you as a member of Florida Blue. What did you think of this open enrollment guide? Please take a moment to scan this QR code and give us some feedback.



Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Florida, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.